

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

30097

1. PLACE OF DEATH

County Greene Registration District No. 318
 Township Springfield Primary Registration District No. 2815 N Grant Ave
 City Springfield No. 2815 St. Grant Ward 2001 Ave

File No. _____
 Registered No. 611
 St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 716 N. Grant St., _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec 9 - 1858</u>				
7. AGE	YEARS <u>72</u>	MONTHS <u>0</u>	DAYS <u>26</u>	IF LESS than 1 day, _____ hrs. _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>House work</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____				

9. BIRTHPLACE (CITY OR TOWN) Ill
 (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Samuel Rudy</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Switzerland</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY)

14. INFORMANT Samuel Utiger
 (Address) Springfield, Mo.

15. FILED Oct 7 1927 Oct Forst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/5 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 6 P m.

THE CAUSE OF DEATH* WHY IT FOLLOWS:
General shock from injuries - struck by motorcycle,
3:11 P.M. (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Broken left arm & Both legs, Broken, fracture left hip - accident -
 18. WHERE WAS DISEASE CONTRACTED at home 2815 N. Grant Ave

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? 1858
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) Jewell E. Mudd M. B. S.
716 N. Grant (Address) 534 St. Louis St

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL East Lawn Cemetery DATE OF BURIAL Oct 7 1927

20. UNDERTAKER W. Klingner & Co. 424 E. Paul ADDRESS Springfield, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

23 1927

