

JAN 23 1929

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

Do not use this space.

40275

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield

M. Hub 318
Registration District No. 318
Primary Registration District No. 2001
(No. 338 W. Wash)

File No. _____
Registered No. 840
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 919 E. L. St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lucille Jones

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 30 - 1897

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
31 2 1

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Tenn.

10. NAME OF FATHER Jim Anderson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Tenn.

12. MAIDEN NAME OF MOTHER Anna Seruggo

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Tenn.

14. INFORMANT Lucille Thompson (Address) 919 E. L.

15. FILED 12-3-28 Ch. Horst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-1-28

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1928, to 12-1-28, 1928 that I last saw h. alive on 12-1-28, and that death occurred, on the date stated above, at 8:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bullet wound left lung
173
Homicidal
(duration) 1/2 hour yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 197
(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH: _____

0 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____ WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS _____ (Signed) Marion C. Stone, M. D. 12-3-28 (Address) Springfield Mo.

*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 Memphis Tenn. DATE OF BURIAL 12-3-28

20. UNDERTAKER W. H. Kove ADDRESS Market

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.

