

JUN 25 1929

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

Do not use this space.

17830 *Per*

1. PLACE OF BIRTH

County Greene Registration District No. 318
Township Springfield Primary Registration District No. 2001
City Springfield (No. 657 Loren)

File No.
Registered No. 392
St. Ward)

2. FULL NAME

Leda Clippard
(a) Residence. No. 657 Loren 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 m 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Maud Clippard

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 1-1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 2 12

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

9. BIRTHPLACE (CITY OR TOWN) Laflin
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Andrew Clippard

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

12. MAIDEN NAME OF MOTHER Sarah Lloyd

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

14. INFORMANT Mrs. Maud Clippard
(Address) Springfield Mo.

15. FILED 5-14-29 Geo. J. Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-13-29

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1929, to May 13, 1929.
that I last saw him alive on May 13, 1929, and that death occurred, on the date stated above, at 12:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
acute indigestion
cause unknown
118°C (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 112°C (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED home
IF NOT AT PLACE OF DEATH, DATE OF

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) U. F. Kern M. D.
5-13, 1929 (Address) 610 W. 12th 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 Cape Girardeau, Mo. DATE OF BURIAL 5-16-1929

20. UNDERTAKER Alma Schmeyer ADDRESS 534 S. Main

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.

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