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

Do not use this space.

30533

1. PLACE OF DEATH
County: Greene
Township: Springfield
City: (No. 2409 N. Summit St. Ward)
Registration District No. 318
Primary Registration District No. 2001
File No.
Registered No. 635

2. FULL NAME: Thomas J. Fox
(a) Residence. No. 2409 N. Summit 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Kettie Fox

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 11-1865

7. AGE: Years 64 | Months 4 | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Stationery Engineer
(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): Ill

PARENTS
10. NAME OF FATHER: John Fox
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Hannah Davis
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: Mrs. Kettie Fox
(Address): Springfield, Mo.

15. FILED 9-2 1929 Lon Sharp Reg

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sep. 2 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19..., that I last saw him dead alive on Sep. 2, 1929, and that death occurred, on the date stated above, at 3 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Rupture pulmonary artery 92A
" Hemorrhage 99B
114B
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Mitral Stenosis
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Murray C. Stone, Coroner, M. D.
Sep. 2, 1929 (Address)

*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: Cemetery, Mo.
DATE OF BURIAL: Sep 3 1929

20. UNDERTAKER: J. W. Klingner
ADDRESS: Springfield

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Greene — Registration District No. 318 — File No.
Township: — Primary Registration District No. 2001 — Registered No. 633
City: Springfield (No. ..... St. ..... Ward)

2. FULL NAME: Thomas J. Fox

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 9-2, 1929 Lou Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 2 1929

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 ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ruptured Pulmonary Artery Hemorrhage
Endarteritis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ....., M. D.
, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1929
30533