

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

Do not use this space.
Lemmon & Fassenden
File No. 40,840
Registered No. ave St. _____ Ward _____

1. PLACE OF DEATH

County Greene Registration District No. 318
Township _____ Primary Registration District No. 2001
City Springfield (No. 2348) N. Lyon

2. FULL NAME

(a) Residence. No. 2348 N. Lyon Ave. 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 14 - 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
71 | 11 | 25

8. OCCUPATION OF DECEASED Retired Merchant
(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) N. Y.
(STATE OR COUNTRY)

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs. C. M. Brandt
(Address) Springfield, Mo.

15. FILED 12-27-29 Geo. Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 19, 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 19, 1929, to Dec 19, 1929, that I last saw him alive on Dec 19, 1929, and that death occurred, on the date stated above, at 9 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer Stomach
463 (duration) about 8 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 440 (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? No

WHAT TEST CONFIRMED DIAGNOSIS? V-Ray
(Signed) E. M. Ferrindes, M. D.

Dec 20, 1929 (Address) 5 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 East Lawn Cemetery DATE OF BURIAL Dec 21, 1929

20. UNDERTAKER J. W. Klingner ADDRESS, No. 246 Canal St

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

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Mr. J. A.