

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

Do not use this space.

20122

1. PLACE OF DEATH

County Springfield Registration District No. 314 File No. 301
 Township Springfield Primary Registration District No. 1001 Registered No. _____
 City Springfield (No. St. Johns Hospital) St. _____ Ward _____

2. FULL NAME

Charles A. Varnall
 (a) Residence, No. _____ St. _____ Ward _____ (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Margaret Mary
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 17 1884
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 50 3 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Stationery Eng
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

FATHER 13. NAME Unknown 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Mary Melinda Dull 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Margaret Varnall
Springfield Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys DATE 6-27-34

19. UNDERTAKER (ADDRESS) Leander H. Lammeyer
Springfield Mo

20. FILED 6-29 1934

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-23-34

22. I HEREBY CERTIFY That I attended deceased from June 15 1934 to June 23 1934
 I last saw him alive on June 23 1934 Death is said to have occurred on the date stated above, at 7 A. m.
 The principal cause of death and related causes of importance were as follows:

Degenerative Myocarditis
HSE
930
 Other contributory causes of importance: Cancer of Liver
 Date of onset about 2 mos ago
44
6 mos ago
ago

Name of operation None Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury None
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____

(Signed) Robert J. Williams, M. D.
 (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.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

621 21 1934

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31
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6-27-34
Springfield Mo
Robert J. Williams
Springfield Mo

