

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

(No. **City**)

St.

Ward)

2. FULL NAME

(a) Residence, No. **315 S. Parkway**

Ward. **25**

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **12** yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

37761

File No.

0214

Registered No.

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

Unknown

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

April 13 - 1888

7. AGE

YEARS **49**

MONTHS **6**

DAYS **8**

If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Machinist

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)

Unknown

13. NAME

Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Unknown

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT

(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE **Springfield, Mo.** DATE **10-22-1934**

19. UNDERTAKER

(ADDRESS)

Wheeler Riley 5007 Waterman Ave

20. FILED

OCT 22 1934

J. F. Brebeck Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

Oct 21, 1934

22. I HEREBY CERTIFY, That I attended deceased from

10/15, 19**34**, to **10/21**, 19**34**.

I last saw him alive on **10/21**, 19**34**. Death is said

to have occurred on the date stated above, at **4:45** m.

The principal cause of death and related causes of importance were as follows:

**Peritonitis, general organism unknown
Enterligamentous ovarian cyst, left.
(Post-operative)**

Other contributory causes of importance:

Name of operation **Removal cyst** Date of **10/19/34**

What test confirmed diagnosis? Was there an autopsy? **No**

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

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? **No**

If so, specify

(Signed) **A. B. ...**, M. D.

(Address) **City, 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

NOV 19 1934

