

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.

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

Do not use this space.

19179

1. PLACE OF DEATH

County

Township

City

Registration District No.

Primary Registration District No.

File No.

Registered No.

St.

Ward

2. FULL NAME

(a) Residence, No.

(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)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, 4 hrs.
or min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc.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
occupation12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

13. NAME

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

15. M maiden NAME

16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)17. INFORMANT
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

19. UNDERTAKER
(ADDRESS)

20. FILED

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-31, 1936

22. I HEREBY CERTIFY, That I attended deceased from
5-31, 1936, to 5-31, 1936

I last saw him alive on 5-31, 1936. Death is said

to have occurred on the date stated above, at 6 a.m.

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

Prematurity, 29th wk.

Date of onset

Other contributory causes of importance:

Name of operation No. 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

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?

If so, specify

(Signed) Joseph D. James, M. D.

(Address)

Springfield, Mo.

Registrar

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

Do not use this space.

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield (No. St. Louis Hosp.)

Registration District No. 318
Primary Registration District No. 2004

File No. 19179
Registered No. 19179
St. St. Louis Ward St. Louis

2. FULL NAME

(a) Residence, No. Infant St. St. Louis Ward St. Louis
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Infant</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 31-1936</u>		
7. AGE YEARS	MONTHS	DAYS
		If LESS than 1 day, <u>7</u> hrs. or <u>7</u> min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	11. Total time (years) spent in this occupation
	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)	

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED 5-31-36 Mr. Chas. A. George Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May-31-1936

22. I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19

I last saw h. alive on, 19. Death is said

to have occurred on the date stated above, at m.

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

Prematurity 29th wk.
Respiratory (respiration)
Stillborn
Date of onset

Other contributory causes of importance:

Name of operation 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

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Joseph H. Dwyer M. D.

(Address) Springfield, Mo.

S-19179