

MAY 20 1937

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

Do not use this space.

1. PLACE OF DEATH

County

Township

City

Registration District No.

Primary Registration District No.

No.

318

2001

File No.

Registered No.

St.

Ward)

16339

0309

2. FULL NAME

(a) Residence, No.

(Usual place of abode)

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

MEDICAL CERTIFICATE OF DEATH

3. SEX *male*
4. COLOR OR RACE *white*
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Widower*

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

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

Dec 26-1854

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.*84**3**12*

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)

*Retired Merchant**In Store*11. Total time (years) spent in this occupation

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

19. UNDERTAKER (ADDRESS)

20. FILED

DATE

1937

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

April 8th 1937

22. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to *April 8th 1937*

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

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

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

Chronic Myocarditis Date of onset*Several years duration**Society*

Other contributory causes of importance:

*Atherosclerosis - Nerve**Cerebral hemorrhage**4 years ago which left him**partially paralyzed*

Name of operation..... Date of.....

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 of injury in any way related to occupation of deceased?

If so, specify.....

(Signed) *W.P. Satt-Keane*, M. D.(Address) *Springfield, Mo**Coscow of Greene County, Mo.*

