

REC'D FEB 15 1939

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

2327
Do not use this space.

PLACE OF DEATH

(a) County GREENERegistration District No. 318(b) Township SPRINGFIELDPrimary Registration District No. 2801Registered No. 53(c) City SPRINGFIELD(d) Street No. 717 S. Douglas St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 717 S. Douglas St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Alice Trago6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 11, 18567. AGE YEARS 83 MONTHS 0 DAYS 9 If LESS than 1 day, hrs. or min.8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. carpenter

9. Industry or business in which work was done, as 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) Ohio13. NAME Wm. Trago14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio15. MAIDEN NAME Malissa Brack16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio17. INFORMANT (ADDRESS) Mrs. Alice Trago Springfield, Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Greenbush DATE Jan. 22, 193919. FUNERAL DIRECTOR (NAME) (ADDRESS) Alvin Labriere Springfield, Mo.20. FILED Jan 22 1939 Chas. A. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 20, 193922. I HEREBY CERTIFY That I attended deceased from 3-22 1938, to Jan. 20 1939I last saw him alive on Sept 28 1938. Death is said to have occurred on the date stated above, at 12 noon m.

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

Dementia cerebrale Date of onset 1-15-39Other contributory causes of importance: arteriosclerosis yrs?Name of operation 0 Date of 0
What test confirmed diagnosis? Clinical Was there an autopsy? no23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? 1 Date of injury 19Where 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 0
Nature of injury 024. Was disease or injury in any way related to occupation of deceased? NO
If so, specify 0(Signed) Leslie R. West, M. D.
(Address) Springfield, Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Greene Registration District No. 318
 (b) Township Springfield Primary Registration District No. 2001 Registered No. 63
 (c) City Springfield (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Geo. William Trago

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-20-39

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

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

I last saw h _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
33 0 9

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

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

Date of onset _____
 Other contributory causes of importance: _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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

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

MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Mar 11 1939 Chas. George Local Registrar

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) Lester R. West, M. D.
 (Address) Springfield Mo

10. CERTIFICATES SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL FULLY AND COMPLETED AS PRESCRIBED BY LAW.

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