OCT 26 1928

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

Do not use this space.
30202

1. PLACE OF DEATH
County Greene — Registration District No. 318
Township Campbell — Primary Registration District No. 2001
City Springfield (No. ..... St. ..... Ward) — File No. ..... Registered No. 629

2. FULL NAME Aaron Herron

(a) Residence. No. 4 E. Mill St., ... Ward.
(Usual place of abode) (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: Male | 4. COLOR OR RACE: Colord | 5. SINGLE, ~~MARRIED~~, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1849

7. AGE: YEARS 79 | MONTHS Unknown | DAYS | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Gardner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Cedar Co
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT Malgie Herron
(Address) # 4 E. Mill Street

15. FILED 9-3 1928 O.C. Horst M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 1 1928

17. I HEREBY CERTIFY, That I attended deceased from July 19, 1928, to July 19, 1928
that I last saw h. alive on July 19, 1928, and that death occurred, on the date stated above, at 11:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral insufficiency
Chronic (duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) W. R. Gowen, M. D
9/1, 1928 (Address) Ash Grove Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ash Grove Mo — DATE OF BURIAL Sep 3 1928

20. UNDERTAKER W. P. Campbell — ADDRESS 867 Washington Ave

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.