

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

Do not use this space

Robert
125270

1. PLACE OF DEATH
 39 County Greene Registration District No. 318
 3 Township Springfield Primary Registration District No. 2001
 5 City Springfield (No. 543 N. Webster St. 890 Ward)

2. FULL NAME Rose Mary Happe
 (a) Residence, No. 543 N. Webster St. Ward. _____
 (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 Female 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 H. H. Happe

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 7 - 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 9 11

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 235

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) Springfield Mo

FATHER 13. NAME Christian Walker
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield Mo

MOTHER 15. MAIDEN NAME Mary A. Miller
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield Mo

17. INFORMANT (ADDRESS) Springfield Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys DATE 12-21-1937

19. UNDERTAKER (ADDRESS) H. H. Happe
Springfield Mo

20. FILED 12-19-37 Ralph W. Langston Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 18 1937

22. I HEREBY CERTIFY, That I attended deceased from Dec 18 1937, to Dec 18 1937
 I last saw her alive on Dec 18 1937 Death is said to have occurred on the date stated above, at 1 P m.
 The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage
 Other contributory causes of importance: _____
 Name of operation none 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? no 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 none
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) Robert Williams, M. D.
 (Address) Springfield Mo

Date of onset
Dec 19-37

WRITE PLAINLY; WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

JAN 23 1938

