

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.

FEB 3 1936

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

Do not use this space.

39236

1. PLACE OF DEATH

County Greene Registration District No. 318  
Township St. John Hospital Primary Registration District No. 2001  
City Springfield (No. St. John's)

File No. \_\_\_\_\_  
Registered No. 660  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward Urbana, Mo.  
(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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Sam Butner</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>1914</u> ✓				
7. AGE	YEARS <u>21</u>	MONTHS ✓	DAYS ✓	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>			
	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 occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Dallas Tex Mo.</u>				
MOTHER	13. NAME <u>Bill Garrison</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Dallas Tex Mo.</u>			
	15. MAIDEN NAME <u>Minnie Garrison</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Dallas Tex Mo.</u>			
17. INFORMANT <u>Sam Butner</u> (ADDRESS) <u>Urbana Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>One Post</u> DATE <u>Dec-5-35</u>				
19. UNDERTAKER <u>R. B. Jones</u> (ADDRESS) <u>Springfield Mo.</u>				
20. FILED <u>12-5-35</u> 19 <u>35</u> <u>W. H. Longston</u> Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec-3-35

22. I HEREBY CERTIFY, That I attended deceased from Nov 25 1935 to Dec 3 1935  
I last saw her alive on Dec 3 1935 Death is said to have occurred on the date stated above, at 7:45 a.m.  
The principal cause of death and related causes of importance were as follows:  
Several Venitronics following rupture of appendix  
Date of onset Nov 25-35

Other contributory causes of importance: 101

Name of operation Hypodermomy Date of Nov 25-35  
What test confirmed diagnosis? operation 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 or injury in any way related to occupation of deceased?  
If so, specify James C. Dewey M. D.  
(Signed) Springfield Mo.  
(Address) Medical Arts Bldg.

