

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

Do not use this space.

NOV 17 1937

37674

1. PLACE OF DEATH

County Greene
 Townshp Springfield
 City Springfield

Registration District No. 318
 Primary Registration District No. 2001
Springfield Baptist Hospital

File No. 992
 Registered No. 992
 St. Miller, Mo Ward

2. FULL NAME

(a) Residence, No. Miller, Mo St. Miller, Mo 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.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 12 1937

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ebber Hood

22. I HEREBY CERTIFY, That I attended deceased from Oct 7 1937 to Oct 12 1937

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 29, 1891

I last saw her alive on Oct 12 1937 Death is said to have occurred on the date stated above, at 3 P.

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>46</u>	<u>1</u>	<u>13</u>	

The principal cause of death and related causes of importance were as follows:
Pulmonary embolus Date of onset

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.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

Hemorrhage
 Other contributory causes of importance:
Hysterectomy

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lawrence Co Mo

Name of operation Hysterectomy Date of 10/17/37

13. NAME Clifton Jones

What test confirmed diagnosis? Was there an autopsy?

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lawrence Mo

15. MAIDEN NAME Anna Sexton

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lawrence Mo

17. INFORMANT (ADDRESS) W. E. Hood Miller, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Look Out Mt. View DATE Oct 14 1937

19. UNDERTAKER (ADDRESS) Forsell Funeral Home

20. FILED Oct 14 1937 Chas H. Leonard Registrar

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury
 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? No
 If so, specify
 (Signed) E. G. Osborn M. D.
 (Address) 618 Broadway Bldg

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

111B

J. K. Lumb

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

37674
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1. PLACE OF DEATH

(a) County Greene Registration District No. 318
 (b) Township _____ Primary Registration District No. 2001 Registered No. 992
 (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 Gertie Alice Hood

(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

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
46 1 13

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

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 _____ 19__

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 12 1939

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

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

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

Pulmonary Embolus
operation performed for
pericardial infarction
myocardial infarction
hysterectomy 12/10
 Other contributory causes of importance _____

Date of onset

Name of operation Hysterectomy 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? _____ 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) E. C. Roseberry M. D.

(Address) 618 Woodruff

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

