

REC'D MAY 18 1938

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

14659
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 318
(b) Township Springfield, Mo. Primary Registration District No. 2001 Registered No. 356
(c) City Springfield, Mo. (d) Street No. Springfield Baptist Hospital 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 Mrs. Emma McElhany 245

(a) Residence, No. Route # 2 Republic, Mo. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/24/1938

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

22. I HEREBY CERTIFY, That I attended deceased from 4/19/1938 to 4/24/19386. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 20, 1860I last saw h. c. r. alive on 4/24/38 Death is said

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 10 4

to have occurred on the date stated above, at 5:45 P.M.

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Wife
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

R. Bronchopneumonia Date of onset 4/16/38
1070

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

Other contributory causes of importance:

Acute Cardiac dilatation 4/19/38
Mediastinal Tumor
Similarity of Genl. Arteriosclerosis

13. NAME Ben. McCormack14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

Name of operation..... Date of.....
What test confirmed diagnosis? X-ray Was there an autopsy?

15. MAIDEN NAME Unknown16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

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.

17. INFORMANT (ADDRESS) J. D. Manley18. BURIAL, CREMATION, OR REMOVAL PLACE Republic, Mo. DATE April 26, 1938

Manner of injury.....
Nature of injury.....

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. H. Lohmeyer20. FILED Apr 26 1938 Chas. A. George, Jr. Local Registrar.

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify..... (Signed) Edward G. Hall, M. D.
(Address) 500 2nd Street, Springfield, Mo.

1070

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 comply 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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Do not use this space.

1. PLACE OF DEATH
 (a) County Greene Registration District No. 218
 (b) Township Springfield Primary Registration District No. 2001 Registered No. 356
 (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 Emma McElhanev
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wed (write the word)

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

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

7. AGE YEARS 77 MONTHS 10 DAYS 4 If LESS than 1 day, _____ hrs. or _____ min.

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 _____

FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 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 6/10/38 Darwood H. Hall Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/24/38

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:
R. Broncho - Pneumonia Date of onset 10/70
 Other contributory causes of importance:
Acute Cardiac dilatation
Mediastinal tumor
(?) Malignancy undetermined as to
 Name of operation Med. Tumor Date of _____
 What test confirmed diagnosis? X-ray only 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 _____ (Signed) Darwood H. Hall, M. D.
 (Address) 509 Holland Bldg. Springfield Mo

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

SUPPLEMENTARY

