

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.

AUG 24 1938

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

James
25846
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 316
 (b) Township _____ Primary Registration District No. 2001 Registered No. 576
 (c) City Springfield (d) Street No. St. Johns 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 Mary Miller

(a) Residence, No. Lebanon Mo. St. Lebanon Mo
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 16, 1896

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
42 5 7

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

13. NAME B. C. Hooper

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sleeper Missouri

15. MAIDEN NAME Martha Wallis

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Palmer Funeral Home
 (ADDRESS) Lebanon Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Lebanon Mo. DATE July 26 1938

19. FUNERAL DIRECTOR (NAME) Herman Hohmeyer
 (ADDRESS) Springfield, Mo

20. FILED July 26, 1938 Charles H. Stearns Mo
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 23 1938

I HEREBY CERTIFY, That I attended deceased from July 20 1938 to July 23 1938
 I last saw her alive on July 23 1938. Death is said to have occurred on the date stated above, at 2:45 A.M.

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

Circulatory failure
Adynamic illness

Date of onset

Other contributory causes of importance:

Name of operation Myocardium Hypertrophy site of 7-21-38
 What test confirmed diagnosis? Chemical 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) Joseph O. Lewis M. D.
 (Address) Springfield Mo.

2050

STATEMENT TO BE MADE BY THE LICENSED EMBALMER
CERTIFICATE NO. _____
STATE OF _____

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, Yes

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed Loakin Gormin

Licensed Embalmer No. 3177

P. O. Address Springfield, Mo.

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.

Vertical text on the right edge of the page, possibly a stamp or label.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

25346
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 318
 (b) Township _____ Primary Registration District No. 2001 Registered No. 576
 (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 Mary Miller

(a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 23, 1938

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

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 42 5 7

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.
 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 _____

Circulatory Failure Date of onset _____
Adenomyomata

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

Other contributory causes of importance: 54

FATHER 13. NAME

Name of operation Myomelectomy hysterectomy Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

MOTHER 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.

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 Joseph D. James M. D.
 (Address) Springfield Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH, TIME, PLACE, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important.

