

NOV 17 1938

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

35682
Do not use this space.

1. PLACE OF DEATH
 (a) County Greene Registration District No. 318
 (b) Township Springfield Primary Registration District No. 2001 Registered No. 748
 (c) City Springfield (d) Street No. City 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Emma Greer
 (a) Residence, No. 529 E. Pine 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 M 4. COLOR OR RACE Caucasian 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept-28-1875

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day, hrs. or min.
<input checked="" type="checkbox"/>	<u>63</u>	<u>0</u>	<u>10</u>	<u>5</u>

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct-8-1938

22. I HEREBY CERTIFY, That I attended deceased from 7/20/1938, to 10/8/1938.
 First saw her alive on 10/7/1938. Death is said to have occurred on the date stated above, at 5:35 a.m.
 The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage Date of onset 10/4/38
121

Other contributory causes of importance:
Myocardial Infarction
Rheumatic Heart Disease
Chronic Nephritis

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

FATHER
 13. NAME Samuel Hester
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
 15. MAIDEN NAME Jane Wilson
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Margaret Hester 529 E. Pine

18. BURIAL, CREMATION, OR REMOVAL PLACE Lincoln Memorial - Oct-10-1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. Y. Smith 1702 W. Jefferson

20. FILED Oct 10 1938 Chas. A. George Local Registrar

Name of operation _____ 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) W. E. Jenkins M. D.
 (Address) 306 College St. Springfield, Mo.

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.

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,

Herbert V Smith

....., or by

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

Signed.....

Herbert V Smith

Licensed Embalmer No.....

3324

P. O. Address.....

702 - 17 - Jefferson

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.