

097 NOV 17 1938

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

35698  
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 318  
(b) Township Springfield Primary Registration District No. 2001  
(c) City Springfield (d) Street No. Burge Hosp. Registered No. 766  
(If death occurred in Hospital or Institution, write its name instead of street and number) St.  
(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

(a) Residence, No. 1631 E. Thoman St.  (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) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 10 - 1936

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
✓ 2 0 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child at Home  
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) Springfield Mo.

FATHER 13. NAME Walter Leightwine

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

MOTHER 15. MAIDEN NAME Billia Gates

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

17. INFORMANT (ADDRESS) Walter Leightwine Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL Green Lawn DATE Oct 17, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. W. Lingner Springfield, Mo.

20. FILED 10-17-38 Chas. A. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 16, 1938

22. I HEREBY CERTIFY, That I attended deceased from 10-14-38, 19... to 10-16-38, 19...

I last saw her alive on 10-16-38, 19... Death is said to have occurred on the date stated above, at 8:30 A.M.  
The principal cause of death and related causes of importance were as follows:

Bronchopneumonia Date of onset 10-14-38

Other contributory causes of importance: 10/14

Name of operation..... Date of.....  
What test confirmed diagnosis?..... 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? No  
If so, specify.....

(Signed) Chas. A. George, M. D.  
(Address) 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,

*Roy A. Gavin #1763* of *Wenden D. Koblett #4003* by *Mr. Max Rhodes*

Registered Apprentice No. *117*, working under my personal supervision.

Signed

*J. B. Klingner*

Licensed Embalmer No. *3358*

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.