

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.

REC'D JAN 14 1938

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

43067  
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 378

(b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 927

(c) City SPRINGFIELD (d) Street No. Springfield Baptist Hospital St. Springfield Baptist Hospital  
(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 Ms. Romane Lucas Hall

(a) Residence, No. 725 E. Loren 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 married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 12 1912

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>✓ 26</u>	<u>2</u>	<u>22</u>	

OCCUPATION

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

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) Shreveport La

FATHER

13. NAME Clarence H. Lucas

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wahjangan Michigan

MOTHER

15. MAIDEN NAME Wanda Luise

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

17. INFORMANT (ADDRESS) William F. Hall 725 E. Loren

18. BURIAL, CREMATION, OR REMOVAL PLACE Greenlawn DATE Dec 5 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ercel P. Prieme Springfield, Mo

20. FILED Dec 5 1938 Chas. George Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

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

22. I HEREBY CERTIFY, That I attended deceased from Nov. 20 1938 to Dec. 4 1938

I last saw him alive on Dec 4 1938 Death is said to have occurred on the date stated above, at 6:45 a.m.

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

Leucopneumonia Stenitica

Date of onset 11-5-

Other contributory causes of importance: Thrombocytopenic Purpura

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 Rouyed & Galbraith (Signed) Springfield Mo, M. D.

**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, .....

*Ralph Quenne* ....., or by .....

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

Signed.....  
*Ralph Quenne*

Licensed Embalmer No. *3681*

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.**