

REC'D FEB 15 1939

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

Dr. Ronald E. Elkins  
2284  
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 310  
(b) Township \_\_\_\_\_ Primary Registration District No. 2901 Registered No. 19  
(c) City SPRINGFIELD (d) Street No. 618 S. Jefferson 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

(a) Residence, No. 618 S. Jefferson 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 Female  
4. COLOR OR RACE white  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OF (OR) WIFE OF John M. Dec.  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 20, 1845  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
93 10 14  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none  
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) Wisconsin

13. NAME Sharon Day

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York City

15. MAIDEN NAME Emily Bigelow

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Nova Scotia

17. INFORMANT (ADDRESS) Oscar D. Christman Jr. Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Greenwood DATE Jan 6, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Charles A. George, No. 1000 Springfield, Mo.

20. FILED Jan 6, 1939 Charles A. George, No. 1000 Springfield, Mo. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 4, 1939

22. I HEREBY CERTIFY That I attended deceased from Jan 4, 1939, to Jan 4, 1939  
Last saw h. alive on August 19, 1938 Death is said to have occurred on the date stated above, at 7:30 p.m.  
The principal cause of death and related causes of importance were as follows:

Terminal Bronchial Pneumonia  
Other contributory causes of importance: Cardio-Vascular Disease

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) Ronald E. Elkins, 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.

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**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.**