

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

Dr. Horst
2305
Do not use this space.

REC'D FEB 15 1939

1. PLACE OF DEATH

(a) County GREENE Registration District No. 316
 (b) Township _____ Primary Registration District No. 2001 Registered No. 40
 (c) City SPRINGFIELD (d) Street No. 2000 N. Beaud 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. 2000 N. Beaud 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John C. Garrett Dec
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 18 1852
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
✓ 86 1 26
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home
 9. Industry or business in which work was done, as saw mill, bank, etc. Home
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 14 1939
 22. I HEREBY CERTIFY, That I attended deceased from June 1 1936 to Jan 14 1939
 that saw her alive on Jan 13 1939. Death is said to have occurred on the date stated above, at 7:03 a.m.
 The principal cause of death and related causes of importance were as follows:

Obstruction of intestines
Cause not known
 Date of onset Jan 7 1939
 Other contributory causes of importance: Mucous colitis about 1936

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

FATHER 13. NAME James F. Finley

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

MOTHER 15. MAIDEN NAME Mary Lacey

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

17. INFORMANT (ADDRESS) Mrs. Lucille Simmons 2000 N. Beaud

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Park DATE Jan 16 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alvin J. Schmeyer Springfield, Mo.

20. FILED Jan 16 1939 Chas. A. George Local Registrar

Name of operation None Date of _____
 What test confirmed diagnosis? Clinical 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) Dr. Horst M. D.
 (Address) H. 30 South Springfield, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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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.