

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.

APR 13 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

10860

Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 316
 (b) Township Scampbell Primary Registration District No. 2001 Registered No. 275
 (c) City SPRINGFIELD or (d) Street No. 524 S. Campbell St.
 (e) Length of residence in city or town where death occurred 10 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 524 S. Campbell St. 10860 (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 (write the word) Widow

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
80 2 3

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House
 9. Industry or business in which work was done, as saw mill, bank, etc. Keeper
 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)

FATHER

13. NAME W.M. Cox
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER

15. MAIDEN NAME Martha Pierce
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE Willow Springs DATE March 31, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

20. FILED 3-30 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 30 1939

22. I HEREBY CERTIFY, That I attended deceased from 3, 20, 39 19, to 3, 30, 39 19.

I last saw her alive on 3, 29, 39 19. Death is said to have occurred on the date stated above, at 1:10 A. M.
 The principal cause of death and related causes of importance were as follows:

Pneumonia, lobar

Date of onset 3, 20, 39

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? Phys. 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? _____
 If so, specify _____
 (Signed) J. Musick - 1 M. D.
 Address Springfield, Mo.

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.