

REC'D APR 10 1939

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

10873
Do not use this space.

1. PLACE OF DEATH **GREENE** ²
 (a) County.....
 (b) Township Franklin
 (c) City Springfield (d) Street No. Fairgrove Mo. R.R. 2 St.
 (e) Length of residence in city or town where death occurred 5 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME Dollie Paul
 (a) Residence, No. Fairgrove Mo. R.R. 2 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 5 1880
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
58 5 14
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House keeper
 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
 13. NAME James Paul
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Kentucky
 15. MAIDEN NAME Sarah Marshall
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Tennessee

17. INFORMANT Ely Paul
 (ADDRESS) Fairgrove Mo. R.R. 2
 18. BURIAL, CREMATION, OR REMOVAL PLACE Clear Creek DATE March 22 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. C. Thieme Springfield Mo.
 20. FILED Mar 25 1939 Allen Barnes Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 19 1939
 22. I HEREBY CERTIFY, That I attended deceased from 18 March, 1939 to 19 March, 1939
 I last saw her alive on 19 March 30, 1939. Death is said to have occurred on the date stated above, at 11 A m.
 The principal cause of death and related causes of importance were as follows:

apoplexy
g. Paul
 Date of onset

Other contributory causes of importance:
 Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....
 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) E. Paul H. C. J. M. D.
 (Address) 219 1/2 West Olive st

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.

WRITE PLAINLY, WITH OR WITHOUT PENCIL

X-14228

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 Thorne

or by

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

Signed.....

Ralph Thorne

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.