

DEC'D JUN 13 1939

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

18679  
Do not use this space.

1. PLACE OF DEATH  
 (a) County GREENE Registration District No. 322  
 (b) Township Franklin Primary Registration District No. 5446 Registered No. 8  
 or City SPRINGFIELD (d) Street No. Fair Grove Mo. R#2 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 IDA HAWORTH  
 (a) Residence, No. FAIR GROVE R.E.D. #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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 3-1910

7. AGE YEARS 28 MONTHS 11 DAYS 18 If LESS than 1 day, hrs. or min.

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSEWIFE  
 9. Industry or business in which work was done, as saw mill, bank, etc. In home  
 10. Date deceased last worked at this occupation (month and year) ✓ 11. Total time (years) spent in this occupation ✓

FATHER  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI  
 13. NAME ROBERT ESTES  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI

MOTHER  
 15. MAIDEN NAME MARTLE THOMPSON  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI

17. INFORMANT EARL HAWORTH  
 (ADDRESS) FAIR GROVE R.E.D. #2

18. BURIAL (CREMATION OR REMOVAL) PLACE Central Cemetery DATE May 22 1939

19. FUNERAL DIRECTOR (NAME) J.W. KLINGNER & CO  
 (ADDRESS) 424 E. COM'L ST. SPGD. MO.

20. FILED May 22 1939

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from 11:20 PM 1939  
 I last saw him alive on May 21 1939 Death is said to have occurred on the date stated above, at 11:20 PM m.  
 The principal cause of death and related causes of importance were as follows:  
Fractured skull  
Crushed left shoulder  
210 lbs  
 Other contributory causes of importance:  
Fractured lower jaw  
Automobile accident  
(collision) 2 cars

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. Highway 65 50 miles north of Springfield

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_ (Signed) J.P. Ferguson 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

*J. B. Kline*

Licensed Embalmer No. 3358

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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

18679  
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 322  
(b) Township Franklin Primary Registration District No. 3446  
(c) City..... (d) Street No..... 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.

Registered No. 8

2. PRINT FULL NAME Ida Hawthorn

(a) Residence, No. .... 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

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

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

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...  
I last saw h..... alive on ..... 19... Death is said to have occurred on the date stated above, at ..... m.

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
28 11 18

Other contributory causes of importance:

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

Date of onset

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

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.....

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE..... 19...

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED July 1 1939 Allan Barnes Local Registrar.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
A. B. - Every item of final record 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.

