

REC'D JUN 8 1939

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

18691
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 318
(b) Township S. Campbell Primary Registration District No. 5440 Registered No. 430
(c) City SPRINGFIELD (d) Street No. B-7 Springfield 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

CHRISTINE AGAIL MCNULEN
(a) Residence, No. B-7 Springfield 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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 3, 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
✓ 1 21

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

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

13. NAME ancel McNulen

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield MO

15. MAIDEN NAME Lessie Orr

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield MO

17. INFORMANT ancel McNulen
(ADDRESS) B-7 Springfield

18. BURIAL, CREMATION, OR REMOVAL PLACE Brookline DATE May 25, 1939

19. FUNERAL DIRECTOR (NAME) Dunn-Hall
(ADDRESS) Springfield MO

20. FILED 5-25-39 Chas. A. George (Address) MO

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 24, 1939

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 3:45 am.
The principal cause of death and related causes of importance were as follows:
Stomach Lymphatics
found dead at home
found dead between

Other contributory causes of importance: 67

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? Yes

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? Yes
If so, specify.....

(Signed) J. P. Ferguson M. D.
2045 Elm

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

Lloyd W. Ford

Licensed Embalmer No. *7910*

P. O. Address *629 W. Washington*

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.

X