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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AUG 14 1939

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

Dr. Coffelt

25621
Do not use this space.

1. PLACE OF DEATH
(a) County GREENE
(b) Township
or
(c) City SPRINGFIELD
Registration District No. 318
Primary Registration District No. 2001
Registered No. 559
(d) Street No. Burge Hospital 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 526 Emma Alma Ganzer
(a) Residence, No. Rural Route #7, Springfield, Mo. St. R. # 7
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 26, 1912
7. AGE: ✓ YEARS 26 MONTHS 10 DAYS 17 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
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. housework
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) Vernon Texas

FATHER
13. NAME Paul Ganzer
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fayetteville Texas

MOTHER
15. MAIDEN NAME Minnie Peters
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fayetteville, Texas.

17. INFORMANT (ADDRESS) R. S. Bailey Route #7, Springfield, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Clear Creek cemetery DATE July 15 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Herman H. Lohmeyer Springfield, Missouri.
20. FILED 7-15 1939 Chas A George M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 13, 1939
22. I HEREBY CERTIFY, That I attended deceased from July 8, 1939, to July 13, 1939
I last saw her alive on July 13, 1939. Death is said to have occurred on the date stated above, at 5 a m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Self induced Septic Abortion	?
175 a	
99	

Other contributory causes of importance:

General Peritonitis	July 8
Multiple lung abscesses	July 10

Name of operation ..... Date of .....
What test confirmed diagnosis? Physical Exam 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) Kenneth Coffelt, M. D.
(Address) 518 Holland Bldg. Springfield, Mo.

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(Licensed Embalmer's Statement on Reverse Side)

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 comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.