

Registration District No. **318**

Primary Registration District No. **2001**

1. PLACE OF DEATH:

(a) County **Greene**  
(b) City or town **Springfield, Mo.**  
(c) Name of hospital or institution **Springfield Baptist Hospital**  
(d) Length of stay: In hospital or institution **6 days.**

In this community **no** years, months or days (Specify whether)

3. (a) PRINT FULL NAME **Hora May Killingsworth**  
3. (b) If veteran, name war **No.** 3. (c) Social Security No. **456**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive **1880** years

7. Birth date of deceased **Dec. 28 1880**  
(Month) (Day) (Year)

8. AGE: Years **58** Months **7** Days **6** If less than one day **hr. min.**

9. Birthplace **Park County Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business **None**

12. Name **John Rice Killingsworth**  
13. Birthplace **Park County Missouri**  
(City, town, or county) (State or foreign country)

14. Maiden name **Amanda Dent**  
15. Birthplace **Dade County Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Margaret Robertson**  
(b) Address **Walnut Grove Mo.**

17. (a) **Rural** (b) Date thereof **Aug. 5, 1939**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Kelly Cemetery**

18. (a) Signature of funeral director **Henry Brown**  
(b) Address **Walnut Grove Mo.**

19. (a) **Aug. 5, 1939** (b) **Chas. George Hill**  
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**  
(c) City or town **Walnut Grove Mo.**  
(d) Street No. **Rural**  
(e) If foreign born, how long in U. S. A. **\_\_\_\_\_** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **4**  
year **1939** hour **6 am** minute **\_\_\_\_\_** M.

21. I hereby certify that I attended the deceased from **July 31, 1939, to Aug 4, 1939**  
that I last saw him **alive on Aug 4**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardio-Vascular Renal disease**

Due to **Fracture neck of rt femur**

Other conditions **None**  
(Include pregnancy within 3 months of death)

Major findings: **None**  
Of operations **None**  
Of autopsy **None**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **accident**  
(b) Date of occurrence **July 30, 1939**  
(c) Where did injury occur **Home** (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? **None** (Specify type of place)  
(e) Means of injury **Fell**  
28. Signature **Daniel J. Hancey** (M. D. or Ch. M.)  
Address **Springfield Mo.** Date signed **8-7-39**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

---

---

**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 the above constitutes grounds for revocation of license.)**

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

X