

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

W. Simpson
29176
State File No. _____
Registrar's No. **660**

SEP 12 1939
Registration District No. **318**

Primary Registration District No. **2001**

1. PLACE OF DEATH:
(a) County **GREENE**
(b) City or town **SPRINGFIELD**
(c) Name of hospital or institution:
2127 N. CAMPBELL
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO** (b) County **GREENE**
(c) City or town **SPRINGFIELD MO.**
(d) Street No. **2127 N. CAMPBELL**
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **MARGARET E. McCALL**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F.** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **OCT 12 1850**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
✓	88	10	13	hr. _____ min.

9. Birthplace **MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business _____

12. Name **GEORGE ALLEN**

13. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)

14. Maiden name **NANCY BARBARA McSEE**

15. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Mrs. Madeline Brown**
(b) Address **2127 N. Campbell**

17. (a) **URIAL** (b) Date thereof **AUG. 27-1939**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MOBERLY MO**

18. (a) Signature of funeral director **John Higgins & Co.**
(b) Address **414 E. Campbell**

19. (a) **5-26-39** (b) **Chad W. George**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **25**
year **1939** hour **5:00** minute _____ M.

21. I hereby certify that I attended the deceased from **6-18-39**
_____, 19____, to **8-24-39**, 19____;
that I last saw her alive on **8-24-39**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: **Senility**
Fract. Neck Left Femur on 6-18-39

Due to _____
Due to _____

Other conditions **Decubitus Ulcers**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **Accident**
(b) Date of occurrence **6-18-39**

(c) Where did injury occur? **Home**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Fall in house
While at work? **No** (Specify type of place) (e) Means of injury **Left Femur**

23. Signature **W. Simpson MD** (M. D. or other) _____
Address **Springfield Mo** Date signed **8-25-39**

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.

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.....
J. B. Kline & Ogle Sloan Jr......, Registered Apprentice No. 232
working under my personal supervision.

Signed J. B. Kline
Licensed Embalmer No. 3358
P. O. Address Spzd 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.