

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32449

Registration District No. 324

Primary Registration District No. 5449

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Greene - Robertson tws
 (b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mollie E. Coger

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

4. Sex Female 5. Color or race White 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 Jan 3 1871
(Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation Home

11. Industry or business Home

12. Name John B. Black

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

14. Maiden name Laranda Rush

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

16. (a) Informant's own signature Mrs. Mark Hinds

(b) Address Springfield No. R # 5

17. (a) Burial (b) Date thereof 9 19 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hindsville Ark

18. (a) Signature of funeral director J. W. Klingner

(b) Address H. 24 E. Commercial

19. (a) Sept. 16, 1939 (b) Mrs. Guey Freeman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
 (c) City or town Rural R5
(If outside city or town limits, write "RURAL")
 (d) Street No. R 5 Springfield
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 15
 year 1939 hour 7:25 minute _____ M.

21. I hereby certify that I attended the deceased from 9-15-39
9 11 5 1939 to _____ 19____;
 that I last saw her alive on 9-5 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma
Stomach + Duodenum
 Due to _____
long time

Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: none
 Of operations _____
 Of autopsy no

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) no
 (b) Date of occurrence no
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
no
 (e) While at work? _____
(Specify type of place) (e) Means of injury

23. Signature D. J. Freeman (M. D. or other) _____
 Address Springfield Date signed 9-15-39

PL. _____
 Cause of DEATH in plain terms, so that it can be understood by all.
 Exact statement of OCCUPATION is very important.
 ALL INFORMATION SHOULD BE CHECKED FOR ACCURACY.
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4/6

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.....

Ogle Stone Jr......, Registered Apprentice No. *232*
working under my personal supervision.

Signed *J.B. Klinger*.....
Licensed Embalmer No. *3358*
P. O. Address *Springfield 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

32449 X
Do not use this space.

1. PLACE OF DEATH
 (a) County Greene Registration District No. 324
 (b) Township Robertson Primary Registration District No. 2449
 (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.

2. PRINT FULL NAME Mollie E. Cogger
 (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

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>68</u>	<u>8</u>	<u>12</u>	

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. _____

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) _____

FATHER

13. NAME _____

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

MOTHER

15. MAIDEN NAME _____

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 _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 15, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Cancerous Stomach
Quadruplex
Stomach (primary)
from history of cancer

Date of onset some years

Other contributory causes of importance:
Stomach (primary)
from history of cancer

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 _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) S. J. Freeman, M. D.
 (Address) Springfield Mo.

SUPPLEMENTARY

Every item of information furnished must be stated EXACTLY. PHYSICIAN'S SIGNATURE
 CAUSE OF DEATH in plain text, as do that which be properly classified. Exact statement of OCCUPATION is very important.
 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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