

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

Dr. Burke
36057
Do not use this space.

1. PLACE OF DEATH
(a) County..... GREENE Registration District No..... 315
(b) Township..... Primary Registration District No..... 2001
(c) City..... SPRINGFIELD (d) Street No..... 717 S. Newton 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 Mrs. Agnes Jones
(a) Residence, No. 717 S. Newton St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 11 1868

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
70 11 25

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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) Springfield Missouri (STATE OR COUNTRY)

FATHER
13. NAME Charles C. Avery
14. BIRTHPLACE (CITY OR TOWN) New York (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY)

17. INFORMANT Joe Jones (ADDRESS) Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hazelwood DATE Oct. 8 1939

19. FUNERAL DIRECTOR (NAME) H. H. Lohmeyer (ADDRESS) Springfield, Mo.

20. FILED Oct. 8 1939 Chas. A. George M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 6 1939

22. I HEREBY CERTIFY, That I attended deceased from May 18 1939 to Sept 26 1939
I last saw her alive on Oct 1 1939. Death is said to have occurred on the date stated above, at 11 a.m.
The principal cause of death and related causes of importance were as follows:
Cancer of stomach and intestines

Other contributory causes of importance:

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
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) Dr. W. H. Burke, M. D.
(Address) 710 Woodluff Bldg

77 Becke R.N.

46

state
no.
date

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.....

Randolph Neale

....., Registered Apprentice No. *176*

working under my personal supervision.

Signed *L. Bookin Gunn*

Licensed Embalmer No. *3177*

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.

X

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

36057

Do not use this space.

1. PLACE OF DEATH
 (a) County Greene Registration District No. 318
 (b) Township Springfield Primary Registration District No. 2001 Registered No. 743
 (c) City Springfield (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 Mrs. Agnes Jones
 (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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>70</u>	<u>11</u>	<u>25</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 12-14-39 Chas. C. George, Jr. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 6 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:
Cancer of stomach and intestines
primary of stomach
 Other contributory causes of importance: 46

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) W. H. Burke M. D.
Springfield (Address) Mo.

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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