

Registration District No. **318**

**RECORDED**

Primary Registration District No. **2001**

**747**

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(c) Name of hospital or institution 515 W. Division 2  
(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) 11/10

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 515 W. Division  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME JENNIE KIRKLAND MUELLER

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7<sup>th</sup>  
year 1939 hour 2<sup>15</sup> minute A. M.

21. I hereby certify that I attended the deceased from 10/2, 1939, to 10/7, 1939;  
that I last saw her lx alive on 10/6, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death Diphtheria Definitive

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec. 16 1886  
(Month) (Day) (Year)

8. AGE: Years 52 Months 9 Days 21 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Jenny Kirkland

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

14. Maiden name Susan A. Coates

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

16. (a) Informant's own signature Jacob J. Mueller

(b) Address Springfield Mo

17. (a) Burial, cremation, or removal Removal & Burial (b) Date thereof \_\_\_\_\_  
(Month) (Day) (Year)

(c) Place: burial or cremation Detroit Michigan

18. (a) Signature of funeral director J. B. Lemmon

(b) Address Springfield Mo

19. (a) Oct. 17, 1939 (b) Chas. A. Longenecker  
(Date received local registrar) (Registrar's signature)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Nephritis, Subacute 2  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. B. Lemmon (M. D. or other) M. D.

Address Springfield, Mo. Date signed 10/7-39

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FORM 1-1931

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.

OCT 22 1949

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**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. 3358

P. O. Address.....

**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.

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