

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

39597  
Do not use this space.

1. PLACE OF DEATH **GREENE** Registration District No. **316**  
 (a) County **GREENE** (b) Township **1** Primary Registration District No. **2001**  
 (c) City **SPRINGFIELD** (d) Street No. **425 N. 6th** Registered No. **816**  
 (e) Length of residence in city or town where death occurred **350** yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.  
 2. PRINT FULL NAME **Nella Jean Tatum**  
 (a) Residence, No. **425 N. 6th** St.  (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **Child**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug 6 1939**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
**0 3 4**

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Child**  
 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) **Spokane Mo**

FATHER 13. NAME **Nell Tatum**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Spokane, Mo**

MOTHER 15. MAIDEN NAME **Arlevia Powell**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Springfield Mo**

17. INFORMANT (ADDRESS) **Nell Tatum  
Spokane, Mo**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Spokane, Mo** DATE **Nov. 11 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Hepper Funeral Home  
Springfield, Mo**

20. FILED **Nov 10 1939** **Chas A. George** Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **11-10 1939**

22. I HEREBY CERTIFY, That I attended deceased from **10-15-39**, 19... to **11-10-**, 19**39**

I last saw her alive on **11-9-39**, 19... Death is said to have occurred on the date stated above, at **9:17A.M.**

The principal cause of death and related causes of importance were as follows:

**Obstructive Ky. discephalia** **Sept 1939**  
**(Probably followed meningitis)**

Other contributory causes of importance:

Name of operation..... Date of.....  
 What test confirmed diagnosis? **Culture** Was there an autopsy? **no**

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? **no**  
 If so, specify.....

(Signed) **Urban Busch**, M. D.  
 (Address) **Springfield, Mo**

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.

792

**STATEMENT BY LICENSED EMBALMER**

X

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 conform 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.

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1. PLACE OF DEATH

(a) County Greene Registration District No. 318  
 (b) Township Springfield Primary Registration District No. 2001 Registered No. 816  
 (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

Mola Jean Tatum  
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) child

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-10, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

The principal cause of death and related causes of importance were as follows:

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 \_\_\_\_\_

Obstructive Hydrocephalus - probably followed meningitis - (non-epidemic suppurative)

12. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

Other contributory causes of importance: \_\_\_\_\_

13. NAME

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

17. INFORMANT (ADDRESS)

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

Specify whether injury occurred in industry, in home, or in public place.

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

Manner of injury \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

Nature of injury \_\_\_\_\_

20. FILED 1-15-40 Chas A. George Local Registrar

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Urban Busien, M. D.

(Address) Springfield Mo

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 CHOSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

