

Registration District No. **318**

Primary Registration District No. **2001**

Registrar's No. **841A**

1. PLACE OF DEATH: **2**  
 (a) County Greene  
 (b) City or town Springfield  
 (c) Name of hospital or institution 525 E. PINE ST.  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED: **1**  
 (a) State Missouri (b) County Greene  
 (c) City or town Springfield  
 (d) Street No. 525 E Pine  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME MOLLIE E. O'DONAL 354  
 (b) If veteran, name war   
 (c) Social Security No.   
 4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Nov. 23-1961  
 (Month) (Day) (Year)

20. DATE OF DEATH: Month Nov day 19  
 year 1939 hour 9 minute 30 A.M.  
 21. I hereby certify that I attended the deceased from June, 1936, to Nov 18, 1939,  
 that I last saw her alive on Nov 18, 1939,  
 and that death occurred on the date and hour stated above.

8. AGE: Years 77 Months 11 Days 26  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

MEDICAL CERTIFICATION  
 Immediate cause of death Cardiac decompensation  
 Due to Hypertension  
 Due to General arteriosclerosis  
 Other conditions Cerebral (complete)  
 (Include pregnancy within 3 months of death)

9. Birthplace Ky.  
 10. Usual occupation House wife  
 11. Industry or business In home  
 12. Name J.H. Fairman  
 13. Birthplace Unknown  
 14. Maiden name Lillian Graham  
 15. Birthplace Unknown

PHYSICIAN  
 Major findings: Of operations None  
 Of autopsy None  
 Underline the cause to which death should be charged statistically.

16. (a) Informant's full signature M. Fairman  
 (b) Address Springfield, Mo.  
 17. (a) Burial (b) Date thereof Nov 24, 1939  
 (c) Place: burial or cremation Hazlewood Cemetery  
 18. (a) Signature of funeral director J. W. King  
 (b) Address Springfield, Mo. 240  
 19. (a) 11-21-39 (b) W. G. Gunguis  
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 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? Yes (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 28. Signature W. G. Gunguis (M. D. or other) \_\_\_\_\_  
 Address Springfield Mo Date signed 11-2-39

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.

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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. 5763

P. O. Address.....  
Farmington

**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.**