

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.

REC'D DEC 15 1939

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

39631  
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 318  
 (b) Township \_\_\_\_\_ Primary Registration District No. 2001 Registered No. 852  
 (c) City SPRINGFIELD (d) Street No. Burge Hospital 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

616 Mrs. Emma Rebecca Crawford  
 (a) Residence, No. Marshfield, Mo. Rt. 3 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 23, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from Nov 10 1939, to Nov 23 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 6, 1907

I last saw her alive on Nov 22 1939 Death is said to have occurred on the date stated above, at 1:10 A.M.

7. AGE YEARS 32 MONTHS 3 DAYS 17 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. Housewife.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation 10 yr.

Puerperal Septicemia Date of onset Sept 26-39  
(Hemolytic Strep.)

12. BIRTHPLACE (CITY OR TOWN) Webster Co. (STATE OR COUNTRY) Missouri

Other contributory causes of importance: 145

FATHER 13. NAME Mr. John Morrison

Name of operation Blood culture Date of \_\_\_\_\_

FATHER 14. BIRTHPLACE (CITY OR TOWN) Kenn. (STATE OR COUNTRY)

What test confirmed diagnosis? Blood culture Was there an autopsy? No

MOTHER 15. MAIDEN NAME Bell Sinder

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

MOTHER 16. BIRTHPLACE (CITY OR TOWN) Webster Co. (STATE OR COUNTRY) Missouri

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

17. INFORMANT Mr. Wesley Crawford (ADDRESS) Marshfield, Mo.

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

18. BURIAL, CREMATION, OR REMOVAL PLACE Prospect DATE 11-25 1939

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

19. FUNERAL DIRECTOR (NAME) Rainey's Funeral Home (ADDRESS) Marshfield, Mo.

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

20. FILED 11-23 1939 Chas. A. Gunguis Local Registrar.

(Signed) Henry D. Callaway M. D. (Address) Springfield

RETURN TO - AND STATE A-1073  
COMMENTS HERE TO USE  
MAY 1960

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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.....

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.**

X