

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

43364
Do not use this space.

1. PLACE OF DEATH
 (a) County Green Registration District No. 318
 (b) Township So Campbell Primary Registration District No. 2001
 (c) City Springfield (d) Street No. 463 Cherry St. Registered No. 887
 (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
 (a) Residence, No. 463 Cherry St. 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 Female 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 Achel Garrison

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 3 - 1896

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 4 1

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home
 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

FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mr Vernon Mo Lawrence Co
 13. NAME William Seamon
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

MOTHER
 15. MAIDEN NAME Ann Garner
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lawrence Co Mo

17. INFORMANT (ADDRESS) 4

18. BURIAL, CREMATION, OR REMOVAL PLACE So. Cemetery DATE Dec 8 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mr Vernon Mo Funeral Home

20. FILED 12-6 1939 Chas. H. George M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 4 1939

22. I HEREBY CERTIFY, That I attended deceased from July 1939 to Dec 4 1939
 I last saw her alive on 12/4 1939 Death is said to have occurred on the date stated above, at 9:30 P.M.
 The principal cause of death and related causes of importance were as follows:
Carcinoma Cervix uteri primary Date of onset 5/39
40

Other contributory causes of importance:
Heart Block 12/39
F. Metastases of Carcinoma 5/39

Name of operation Bypass Date of 7/39
 What test confirmed diagnosis? St. Man 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 _____
 Signature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Arnold B. Hill M. D.
 (Address) 500 Holland Bldg
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.

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