

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.

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 922

1. PLACE OF DEATH:
 (a) County Greene
 (b) City or town Springfield
 (c) Name of hospital or institution: Burgs Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME NORA C. ROSS 207
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife James H. Ross
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased April 3 1876
 (Month) (Day) (Year)

8. AGE: Years 63 Months 8 Days 17
 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Isaac Stewart
 13. Birthplace Ind.
 (City, town, or county) (State or foreign country)

14. Maiden name Catherine Duffer
 15. Birthplace Ind.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature James H. Ross
 (b) Address Springfield, Mo.

17. (a) Buried (b) Date thereof Dec 22-1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union, Providence

18. (a) Signature of funeral director J. W. Bunker Co.
 (b) Address Springfield, Mo.

19. (a) DEC 22 1939 (b) Chas. H. George
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Greene
 (c) City or town Springfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2127 N. Howard
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20th
 year 1939 hour 3 minute 15 P. M.

21. I hereby certify that I attended the deceased from 12-11 1939 to 12-20-39
 that I last saw h. on alive on 12/20- 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia
 Duration _____

Due to Malaria

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN
 Underline the cause to which death should be charged statistically

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 Henry F. Knack (M. D. or other) _____
 Address 450 1/2 E. Council Date signed 12/22/39

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

Ogle Stone Jr

Registered Apprentice No.

232

working under my personal supervision.

Signed

Clarence D. Tobler

Licensed Embalmer No.

40057

P. O. Address

Springfield

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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