

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

Do not use this space.
43415
950

1. PLACE OF DEATH **2**

(a) County **GREENE** Registration District No. **315**

(b) Township **1** Primary Registration District No. **2901**

(c) City **SPRINGFIELD** (d) Street No. **1633 Jefferson** St.

(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 **322 Mary M Hutchison**

(a) Residence, No. **1633 S Jefferson** 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 **Widowed**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug 2, 1862**

7. AGE YEARS **77** MONTHS **4** DAYS **28** If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as Sawyer, bookkeeper, etc. **Housewife**

9. Industry or business in which work was done, as saw mill, bank, etc. **In Home**

10. Date deceased last worked at this occupation (month and year) **None** 11. Total time (years) spent in this occupation **None**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Osage County Mo**

13. NAME **John H. Stephens**

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

15. MAIDEN NAME **Catherine Howert**

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

17. INFORMANT (ADDRESS) **Mrs. Maude Lawton Springfield, Mo**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Chenault** DATE **1-1** 19 **40**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Chas. A. George Springfield, Mo**

20. FILED **1/1** 19 **40** **Chas. A. George** Local Registry

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **12-30 1939**

22. I HEREBY CERTIFY, That I attended deceased from **1-3-1939** to **12-30-1939**

I last saw her alive on **12-29 1939**. Death is said to have occurred on the date stated above, at **12 Noon**.

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

Cerebral Hemorrhage Date of onset **2 days**

Hypertension & Atherosclerosis

Other contributory causes of importance:

Name of operation **None** Date of **None**

What test confirmed diagnosis? **None** 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? _____

If so, specify _____ (Signed) **Joseph L. Johnston** 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.

Mr. Johnson - med cert

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.....

Charles Seay

Registered Apprentice No. *204*

working under my personal supervision.

Signed.....

[Handwritten Signature]

Licensed Embalmer No. *1767*

P. O. Address *[Handwritten 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.

[Handwritten marks and signature]