

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. F. Camp

State File No. 10948

Registration District No. 316

Primary Registration District No. 2001

Registrar's No. 235

39
3
6

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH **GREENE**

(a) County **Greene**

(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. John Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **6 days**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mary Cravens Hiatt**

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 **Widowed**

6. (b) Name of husband or wife **R. J. Hiatt** 6. (c) Age of husband or wife if alive **56** years

7. Birth date of deceased **Oct. 6 1856**
(Month) (Day) (Year)

8. AGE: Years **83** Months **4** Days **29** If less than one day hr. _____ min. _____

9. Birthplace **Galatin Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name **William J. Cravens**

13. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Rebecca Bryan**

15. Birthplace **Patis Missouri**
(City, town, or county) (State or foreign country)

18. (a) Informant **Wilbur Hiatt**

(b) Address **Muskogee, Oklahoma**

17. (a) **Burial** (b) Date thereof **March 7 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Park**

18. (a) Signature of funeral director **H. H. Lohmeyer**

(b) Address **Springfield, Mo. 6290**

19. (a) **3/7/40** (b) **Chas. A. George**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**

(c) City or town **Springfield**
(If outside city or town limits, write "RURAL")

(d) Street No. **423 E. Elm**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **5**
year **1940** hour **10** minute **30 p. m.**

21. I hereby certify that I attended the deceased from **Feb. 29** 19**40** to **Mar 5** 19**40**
that I last saw her alive on **Mar 5** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia - Hypostatic.** Duration **1 wk.**

Due to **Fall in her home. Feb. 22 (?) 40**

Due to _____

Other conditions **1 1/2 yr**
(Include pregnancy within 3 months of death)

Major findings: Of operations **none**

Of autopsy **none**

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) **Indirectly from fall.**

(b) Date of occurrence **Feb. 22 (?) 1940**

(c) Where did injury occur? **At her home**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Springfield Missouri - Camp Mower Ave.
(Specify type of place)

While at work? _____ (e) Means of injury **undermining**

23. Signature **F. B. George** (M. D. or other) _____
Address **Springfield, Mo.** Date signed **March 6 40**

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.