

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

10965

State File No. \_\_\_\_\_

261

Registration District No. 368

Primary Registration District No. 2001

Registrar's No. \_\_\_\_\_

39  
36

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

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(c) Name of hospital or institution: 415 E. Division  
(If not in hospital or institution, write street number or location) 7  
(d) Length of stay: In hospital or institution 7 weeks  
In this community 7 weeks  
years, months or days \_\_\_\_\_ (Specify whether)

3. (a) PRINT FULL NAME EULA REBECCA PENDERGRASS

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 single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Sep 30 1895  
(Month) (Day) (Year)

8. AGE: 44 Years 5 Months 13 Days If less than one day hr. min.

9. Birthplace: Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation: School Teacher

11. Industry or business: School Work

12. Name: John Pendergrass

13. Birthplace: Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name: Sarah E. Ross

15. Birthplace: Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Madley Denge

(b) Address: Springfield, Mo.

17. (a) Burial (b) Date thereof: March 16, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Hazliwood

18. (a) Signature of funeral director: C. W. Kingner  
(b) Address: Springfield, Mo.

19. (a) 3/15/40 (b) Chas. A. George  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13  
year 1940 hour 2 minute 00 P. M.

21. I hereby certify that I attended the deceased from 3-13-1940 to 3-13-1940  
that I last saw her alive on 3-13-1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of uterus (fundus)  
Due to: \_\_\_\_\_  
Due to: \_\_\_\_\_

Other conditions: Metastasis to lungs  
(Include pregnancy within 3 months of death)

Major findings: Of operations: None  
Of autopsy: None

Duration  
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: Joseph L. Johnston (M. D. or other) 1  
Address: Springfield, Mo. Date signed: 3-15-40

JAN 10 1950

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 *Warren D. Noblett*.....

Licensed Embalmer No. *4005*.....

P. O. Address *Springfield Mo.*.....

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.