

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. Hall 14874
State File No. _____

MAY 13 1940
Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 330

1. PLACE OF DEATH:

(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. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Sylvia Anthony

3. (b) If veteran, name war _____ 8. (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 October 26, 1880
(Month) (Day) (Year)

8. AGE: Years 59 Months 5 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Springfield, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name George W. Anthony

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

14. Maiden name Mary Dean

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

16. (a) Informant's own signature Dallas Anthony

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 4-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director Alma Tompkins

(b) Address Springfield, Mo.

19. (a) 4/6/40 (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. 711 St. Louis
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3
year 1940 hour 12:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from 3/26/40
to 4/3/40;
that I last saw her alive on 4/3/40;
and that death occurred on the date and hour stated above.

Immediate cause of death Renovant Uraemia Duration 7 days

Due to Chronic Glomerulonephritis 5-20 years

Due to Chronic Cordis-Vascular Renal disease

Other conditions _____
(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) _____
(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? 296
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Herwood E. Hall (M. D. or other) _____
Address 500 Halland Bldg Date signed 4/5/40

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 Harlow Knabb

Licensed Embalmer No. 4065

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.

X