S. No. 2
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I X21492
39

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Dr. H. Knabb

18385

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 228

Registration District No. FILED APR 2 1940

Primary Registration District No. 2001

Registrar's No.

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: City Hosp.
(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)

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. 930½ N. Campbell
(If rural, give location)

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

3. (a) PRINT FULL NAME Linda Lou Rook

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex Famale

5. Color or race White

6. (a) Single, widowed, married, divorced ____

6. (b) Name of husband or wife ____

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased March (Month) 4 (Day) 1940 (Year)

8. AGE: Years | Months | Days — Still born — If less than one day 1 hr. ____ min.

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

10. Usual occupation ____

11. Industry or business ____

FATHER
12. Name M.R. Rook
13. Birthplace Waynesville (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Eldoro Tindale
15. Birthplace Springfield (City, town, or county) Missouri (State or foreign country)

16. (a) Informant M.R. Rook
(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March (Month) 5 (Day) 1940 (Year)
(c) Place: burial or cremation Eastlawn

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 3/5/40 (Date received local registrar) (b) Chas. A. George (Registrar's signature) M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4 year 1940 hour 5 minute 30 p. M.

21. I hereby certify that I attended the deceased from 3-4, 1940, to 3-4, 1940 that I last saw her alive on March 4, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Heart Disease

Due to ____

Due to ____

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

Major findings:
Of operations ____
Of autopsy ____

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? ____ (Specify type of place)
While at work ____ (e) Means of injury ____

23. Signature Henry F. Knabb M.D. (M. D. or other)
Address 450 Jr. Cecil Date signed 3/10/40

(Licensed Embalmer's Statement on Reverse Side)

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. Not Embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

. No. 2B
—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318 Primary Registration District No. 2001 Registrar's No. 228

SUPPLEMENTARY

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: City Hosp (If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (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.

3. (a) PRINT FULL NAME Linda Lou Rook

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

Still Birth one hr min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 6-15-40 (Date received local registrar) (b) W. E. Handley MD (Registrar's signature) AJB

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 4 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw her alive on Mar 4 , 1940; and that death occurred on the date and hour stated above.

Immediate cause of death

Due to This was not a stillborn, lived

Due to for one hour

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Henry H. Knabb (M. D. or other)

Address Springfield Date signed

5-18385