

JUN 13 1940

Registration District No. 3/8

Primary Registration District No. 2001

416

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:
1559 E. Florida 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 5 YEARS
years, months or days)

3. (a) PRINT FULL NAME: ELISABETH SMITH

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: WIDOW

6. (b) Name of husband or wife: JAMES SMITH 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: NOVEMBER 22 - 1855
(Month) (Day) (Year)

8. AGE: Years 1 84 Months 5 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace: WRIGHT CO. MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation: HOUSEWIFE

MOTHER, FATHER

11. Industry or business _____
 12. Name: WALSH LONG
 13. Birthplace: NOT KNOWN 9
(City, town, or county) (State or foreign country)
 14. Maiden name: NOT KNOWN
 15. Birthplace: NOT KNOWN 9
(City, town, or county) (State or foreign country)

16. (a) Informant: Sarah Remmi
 (b) Address: 1559 E. FLORIDA

17. (a) REMOVED (b) Date thereof: MAY - 5 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation: GREENE SPRINGS

18. (a) Signature of funeral director: G.A. Huff

(b) Address: Manfield mo

19. (a) 5-5-40 (b) W.E. Haudley, M.D.
(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.: 1559 EAST FLORIDA
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 4
 year 1940 hour 9 minute 40 P.M.

21. I hereby certify that I attended the deceased from 2 calls
in April 191940 to April 191940
 that I last saw her alive on April 191940
 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of face & neck
of face & neck
 Due to 12/24/37
Stroke
 Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where and injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Where and 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 _____

Signature: Garrett Hogg (M. D. or other) _____
 Address: Springfield Date signed: 5-5-40

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

52

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. 3221

P. O. Address Manassas MD

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18399
Registrar's No. 416

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 318

Primary Registration District No. 2001

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

1. PLACE OF DEATH:

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

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 Elizabeth Smith

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 wid

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 84 Months 5 Days 12 If less than one year, hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 7-9-40 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of prostate Duration 10 or 12 yrs duration

Due to primary seat unknown

Other conditions (Include pregnancy within 3 months of death) 52

Major findings: Of operations Of autopsy

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 Garrett Hogg (M. D. or other) Address Springfield Mo Date signed

SUPPLEMENTARY

