

JUN 13 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. Wm. Kelly
18456

State File No.

Registrar's No.

Registration District No. 318

Primary Registration District No. 2001

482

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:
1850 S. Campbell 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 1 Week
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County _____
(c) City or town Salem
(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 May day 29
year 1940 hour 4 minute 35 p. M.

21. I hereby certify that I attended the deceased from
5-26-1940 to 5-29-1940
that I last saw him alive on 5-28-1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Arterio Sclerosis

Duration

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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 _____

Signature W. Kelly (M. D. or other) _____
Address Springfield, Mo Date signed 5-31-40

3. (a) PRINT FULL NAME Mary Jane Dawson 250

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 John Dawson 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 25 1855
(Month) (Day) (Year)

8. AGE: Years 1 85 Months 4 Days 4 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name John Jacobs

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

14. Maiden name Unknown

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

16. (a) Informant William Dawson

(b) Address Salem, Arkansas

17. (a) Burial (b) Date thereof May 30 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salem, Arkansas

18. (a) Signature of funeral director H.H. Lohmeyer 904

(b) Address Springfield, Mo.

19. (a) May 30, 1940 W. E. Handley M.D.
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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.....

James Osburn
working under my personal supervision.

Registered Apprentice No. *221*

Signed *Paul F. Lohmeyer*

Licensed Embalmer No. *22457*

P. O. Address *Springfield*

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