

No. 2
-11-10-39
5-17-39
-I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

21726

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 496

1. PLACE OF DEATH:

(a) County Bremer
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City 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 126

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Green
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 92 C Lyman
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Ola Doxey Anderson

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Thomas M. Anderson 6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased June 6 1896
(Month) (Day) (Year)

8. AGE: Years 49 Months 11 Days 26 If less than one day _____ hr. _____ min.

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

10. Usual occupation seamstress

11. Industry or business Lincoln School

12. Name Games Doxey

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

14. Maiden name Amanda Potter

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

16. (a) Informant Bethie Lee Jones

(b) Address 921 E Lyman

17. (a) Removal (b) Date thereof June 3 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Albany Miss

18. (a) Signature of funeral director W. Campbell

(b) Address 562 Wash Ave

19. (a) June 3 1940 (b) W. E. Audley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2
year 1940 hour 5 minute 00 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw her alive on June 2, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Urinary Suppression

Surgical Shock Duration 2 days

Due to Subtotal Hysterectomy

for Fibromyoma - nonmalignant

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death) 5/4/19

Major findings: Uterine Fibroid wt 4 pounds

Of operations _____

Of autopsy No

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

(a) Accident, suicide, or homicide (specify) No.

(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 Newton Williams (M. D. or other) _____

Address Springfield, Mo. Date signed 7-2-40

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

Duration
2 days
PHYSICIAN
Underline the cause to which death should be charged statistically.

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.....

H. V. Smith

..... Registered Apprentice No.

working under my personal supervision.

Signed.....

H. V. Smith

Licensed Embalmer No.

3304

P. O. Address

702 - N - Jefferson

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