

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. **318**

Primary Registration District No. **2001**

1. PLACE OF DEATH:

(a) County **Greene**
(b) City or town **Springfield**
(If outside city or town limit, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. John Hosp**
(If not in hospital of institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days**
(Specify whether
In this community **64-11-12** 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 limit, write "RURAL")
(d) Street No. **1003 N. Jefferson**
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME **Helen C. Magee**

(b) If veteran, name war **no** (c) Social Security No. **no**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **W. P. Magee** 6. (c) Age of husband or wife if alive **68** years
7. Birth date of deceased **July 25 1875**
(Month) (Day) (Year)

8. AGE: Years **64** Months **11** Days **12** If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Thomas McNerney**
13. Birthplace **Unknown Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown Henry**
15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **W. P. Magee**
(b) Address **Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **July 9 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Mary**

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

19. (a) **July 9, 1940** (b) **W. E. Handley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **7** year **1940** hour **11** minute **45** p. M.

21. I hereby certify that I attended the deceased from **Aug. 1, 1939** to **July 7, 1940**
that I last saw her alive on **July 7, 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Left Cerebral Hemorrhage (RT - Hemiplegia)** Duration **4 days**
Due to **Generalized Arteriosclerosis** **3 yrs**
Pseudo Bulbar Palsy
Due to **Hypertension** **2 yrs**

Other conditions **Right Cerebral Hemorrhage**
(Include pregnancy within months of death) **11 mos.**
(Left Hemiplegia) PHYSICIAN

Major findings Of operations **none**
Of autopsy **none**
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 **Dorward G. Hall** (M. D. or other) **1**
Address **500 Holland Bldg** Date signed **7/10/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
936

OCT 29 1951

MAY 29 1950

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 Walter E Hamilton

Licensed Embalmer No. 3808

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.

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