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4  
X23159

Registration District No. **516** Primary Registration District No. **2001**

1. PLACE OF DEATH: **GREENE**  
(a) County **Greene**  
(b) City or town **Springfield**  
(c) Name of hospital or institution: **1819 N. Douglas**  
(d) Length of stay: In hospital or institution **2**  
In this community **2**  
years, months or days

3. (a) PRINT FULL NAME **MARTHA E. ROSE**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **210**

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

6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **Dec. 55** years

7. Birth date of deceased **Sep 28 1865**  
(Month) (Day) (Year)

8. AGE: Years **174** Months **11** Days **22** If less than one day hr. min.

9. Birthplace **Greene Co. Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **House work**

11. Industry or business **In home**

12. Name **Thomas W. Wade**

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

14. Maiden name **Septia Ellen Shelton**

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

16. (a) Informant **Mrs. Wilson Dyer**

(b) Address **Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **Sep. 22, 1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Park**

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

19. (a) **Sep. 22, 1940** (b) **W. E. Handley M.D.**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **Greene**  
(c) City or town **Springfield**  
(d) Street No. **1819 N. Douglas**  
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **20**  
year **1940** hour **4** minute **40 A.** M.

21. I hereby certify that I attended the deceased from **1938** to **9/20**, 19**40**.  
that I last saw ~~her~~ alive on **9/19/40**, 19**40**.  
and that death occurred on the date and hour stated above.

Immediate cause of death **Paralysis of Throat**

Due to **Arterio-Sclerosis**

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) **L**

(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) (a) Means of injury

23. Signature **W. E. Handley M.D.** (M. D. or other)

Address **Springfield, Mo.** Date signed **9/20/40**

Duration **1 Week**  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

MOTHER, FATHER

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**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.....

*Ogle Stone Jr.*

Registered Apprentice No. *232*

working under my personal supervision.

Signed *Warren D. Noblett*

Licensed Embalmer No. *4005*

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, fact should be so stated above.

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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **32044**  
Registrar's No. **762**

Registration District No. **318**

Primary Registration District No. **2001**

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

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 (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME **Martha E. Rose**

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

4. Sex **F** 5. Color of hair **W**  
6. (a) Single, widowed, married, divorced **wid**

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

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

8. AGE: Years Months Days If less than one day  
**74 11 22**

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

10. Usual occupation

11. Industry or business

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) (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) **NOV 25 1940** (b) **W. E. Handley MD** (Registrar's signature)

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.

20. DATE OF DEATH Month **11** day **20**  
year hour minute M.

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

Immediate cause of death **Paralysis of throat result of Cerebral Arteriosclerosis**  
Due to **arterio sclerosis**

Due to  
Other conditions (Include pregnancy within 3 months of death)  
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?  
(Specify type of place) While at work? (c) Means of injury

23. Signature **W. E. Handley MD** (M. D.)  
Address **Springfield, Mo.** Date signed

SUPPLEMENTAL

