

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  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Springfield Baptist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 hrs.  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Auley Jane Latimer

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

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

6. (b) Name of husband or wife B.G. Latimer 6. (c) Age of husband or wife if alive Dec years

7. Birth date of deceased Oct 22 1883  
(Month) (Day) (Year)

8. AGE: Years 56 Months 11 Days 1 If less than one day hr. min.

9. Birthplace Hartsville Wright Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business 1

MOTHER FATHER { 12. Name Thomas R. Pearman

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

14. Maiden name Sabert Logan

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

16. (a) Informant Jasper D Latimer

(b) Address Hartsville Mo

17. (a) Burial (b) Date thereof Sept 25 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial of cremation Hartsville Mo

18. (a) Signature of funeral director Gene E. Adrien

(b) Address Hartsville Mo

19. (a) Sept 25 1940 (b) W. E. Handley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wright  
(c) City or town Hartsville Rural (Boone)  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.F.D. #1 North West  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 23  
year 1940 hour 2 minute 20 A. M.

21. I hereby certify that I attended the deceased from Sept 23  
1940 to Sept 23 1940;

that I last saw her alive on Sept 23 1940;

and that death occurred on the date and hour stated above.

Immediate cause of death Shock and myocardial failure

Due to compound fracture left femur Duration 8 hours

Due to compound fracture right femur Duration 8 hours

Other conditions Generalized trauma  
(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) accident

(b) Date of occurrence Sept 22 1940 6 P.M.

(c) Where did injury occur? Highway 60 near Rogersville Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
901 Highway 60  
While at work? (Specify type of place) (e) Means of injury auto accident

23. Signature Daniel L. Yoney (M. D. or other) \_\_\_\_\_

Address Springfield Mo Date signed 9-23-40

210m  
95

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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~~.....  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Gene E. Haldren  
Licensed Embalmer No. 3865  
P. O. Address Hartsville 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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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 32052  
Registrar's No. 773

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

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) (Specify whether

3. (a) PRINT FULL NAME Auley Jane Latimer

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 \_\_\_\_\_ year

7. Birth date of deceased: \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 36 Months 11 Days 1 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

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) \_\_\_\_\_ (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. Haudley M.D. (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Shock and myocardial failure

Due to compound fracture of left femur

Due to compound fracture of right femur

Other conditions General Trauma

Major findings: auto accident - non-collision - continued

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) acc

(b) Date of occurrence Sept 22 1940

(c) Where did injury occur? Highway near Rogersville

(d) Did injury occur in \_\_\_\_\_ home, on farm, in industrial place, in public place? Highway - 60

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Dr. Daniel K. Yancey (M. D. \_\_\_\_\_)

Address Springfield Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

