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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

NOV 12 1940

State File No. 35385

Registration District No. 318 Primary Registration District No. 5439 Registrar's No. 872

1. PLACE OF DEATH:
(a) County GREENE N Campbell
(b) City or town Springfield (RURAL 15th)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural 5th N Grant St Road
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Rural 5th Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. Rural 5th N Grant St Road
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Janet Donaldson Foote
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Widow Unknown
6. (c) Age of husband or wife if alive Dec years
7. Birth date of deceased Feb (Month) 25 (Day) 1870 (Year)

8. AGE: Years ✓ 70 Months 8 Days 0 If less than one day hr. min.

9. Birthplace Ontario (City, town, or county) Canada (State or foreign country)
10. Usual occupation Home
11. Industry or business Home
FATHER
12. Name Unkown
13. Birthplace Unkown (City, town, or county) Unknown (State or foreign country)
MOTHER
14. Maiden name Unkown
15. Birthplace Unkown (City, town, or county) Unknown (State or foreign country)
16. (a) Informant Donald G Foote
(b) Address Port Huron Mich
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn
18. (a) Signature of funeral director J. W. Klingner & Co
(b) Address Springfield Missouri
19. (a) Oct. 26, 1940 (Date received local registrar) (b) W. E. Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25 year 1940 hour 10 minutes 30 P. M.
21. I hereby certify that I attended the deceased from 10/8/40, 19..., to 10/25/40, 19...; that I last saw her alive on 10/10/40, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of colon - primary -
Due to
Due to 46
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations None done
Of autopsy None done

Duration

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? 0 4 4 (Specify type of place)
While at work? (e) Means of injury
23. Signature G. B. Lemmon (M. D. or other) M. D.
Address Springfield, Mo. Date signed 10/26/40

(Licensed Embalmer's Statement on Reverse Side)

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 William Max Thod

Licensed Embalmer No. 407

P. O. Address Spring Lil

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

X