

NOV FEB 14 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

2662

Registration District No. ~~285~~ 944

Primary Registration District No. 5438

State File No. _____

Registrar's No. 48

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution: R. F. D. #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
In this community 1 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL.")
(d) Street No. R. F. D. #2
(If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME A. MINERVA DILLARD

3. (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 married

6. (b) Name of husband or wife James L. Dillard 6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased Nov. 23 1866
(Month) (Day) (Year)

8. AGE: Years 74 Months 0 Days 27 If less than one day hrs min.

9. Birthplace Brookline Mo. 0.
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business In home

12. Name William S. Perkins

13. Birthplace Kentucky 1
(City, town, or county) (State or foreign country)

14. Maiden name Mattha Seal

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

16. (a) Informant James L. Dillard

(b) Address R#1 Springfield, Mo.

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

(c) Place: burial or cremation Southside Cemetery

18. (a) Signature of funeral director J. W. Plummer
(b) Address Springfield, Mo.

19. (a) 12-24-1940 (b) J. W. Plummer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 20 year 1940 hour 12 minute 05 P.M.

21. I hereby certify that I attended the deceased from Jan 2 1940 to Dec 20 1940 that I last saw her alive on Dec 20 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Tubercular Heart Disease Duration 14

Due to Age

Due to 17. 20

Other conditions ✓
(Include pregnancy within 3 months of death)

Major findings: None
Of operations None

Of autopsy None

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) no

(b) Date of occurrence 1

(c) Where did injury occur? 1
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0

(Specify type of place) (e) Means of injury 30

23. Signature Robert J. Neenan (M. D. or other) 1
Address Springfield Mo Date signed 12-24-40

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

MOTHER FATHER

RECEIVED

Greene County Health Office,

County File Number 41-1-7

Date Filed 1/20/46

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.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2662

Registration District No. 944

Primary Registration District No. 5438

Registrar's No. 48

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Jayles T.P.
(If outside city or town limits, write "RURAL" and name of township)
(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 A.T. Minerva Dallas
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 nc

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 Months Days If less than one day
74 0 27 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) Dec-12-1940 (b) Harry Greer (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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20 year 1940 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 _____

Due to _____

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature Robert J. Williams (M. D. or other) _____
Address Princeton, Mo. Date signed _____

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

SUPPLEMENTARY

