

No. 2  
4-13-40  
5-17-40

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Dr. R. Glynn  
State File No. 10666

APR 3 1941

2001

Registrar's No. 193

Registration District No. 316

Primary Registration District No.

39  
2  
6  
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 4 days (Specify whether  
In this community. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Unknown Phelps  
(c) City or town Newburg  
(If outside city or town limits, write "RURAL")  
(d) Street No. Bay H 52  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7  
year 1941 hour 11 minute p. M.

21. I hereby certify that I attended the deceased from MAR 3, 1941, to MAR 7, 1941;  
that I last saw her alive on MAR ch 7, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza + Bronchopneumonia 6 days  
Due to \_\_\_\_\_  
Duration

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 3 1/2 W

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? 984

(Specify type of place) \_\_\_\_\_  
While at work? (e) Means of injury \_\_\_\_\_  
23. Signature Robt Glynn (M. D. or other) MD  
Address Springfield Date signed 3/10/41

3. (a) PRINT FULL NAME Graham, Fern Kent

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 Mr. Walter E. Graham 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased August 24, 1892  
(Month) (Day) (Year)

8. AGE: Years 48 Months 6 Days 13 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business own home

12. Name Frank K. Garey

13. Birthplace Richfield Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Addie White

15. Birthplace Ashley Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Walter E. Graham

(b) Address Newburg Mo

17. (a) Burial (b) Date thereof March 9, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dixon, Missouri

18. (a) Signature of funeral director H. H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 3-9-41 (b) W. E. Handley M. D.  
(Date received local registrar) (Registrar's signature)

**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.....

*James A. Osburn*  
.....  
Licensed Embalmer No. *4185*  
P. O. Address *Quincy, Ill.*

**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.**