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FILED APR 25 1941

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 015 322

Primary Registration District No. 5447A

Registrar's No. 4

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:
at home
(If not in hospital or institution, write street number or location)

(d) Length of stay: - In hospital or institution _____
(Specify whether _____)

In this community Seven yrs
years _____ months _____ days _____

3. (a) PRINT FULL NAME Miss Malinda Ross

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 single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 17 1876
(Month) (Day) (Year)

8. AGE: Years 64 Months 8 Days 18
If less than one day _____ hr. _____ min.

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

10. Usual occupation House keeper

11. Industry or business _____

12. Name W. H. Ross

13. Birthplace Mansfield Mo
(City, town, or county) (State or foreign country)

14. Maiden name Amanda Newton

15. Birthplace Mansfield Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mollie Bell

(b) Address Fair Grove Mo

17. (a) Removal
(Burial, cremation, or removal)

(b) Date thereof Mar 6 1941
(Month) (Day) (Year)

(c) Place of burial or cremation Newton Cemetery

18. (a) Signature of funeral director Ered C. Pheme

(b) Address 1100 Benville St. Spg Mo

19. (a) Mar 10, 1941
(Date received local registrar)

(b) Allan Baines
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Fair Grove Mo
(If outside city or town limits, write "RURAL")

(d) Street No. Rt 2
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 5th
year 1941 hour 1 minute A M.

21. I hereby certify that I attended the deceased from 3-3-1941 to 3-5-1941
that I last saw her alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Influenza

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) _____

(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?
203
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. H. Bell MD (M. D. or other) 0
Address Springfield Mo Date signed 3-6-41

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

RECEIVED

Greene County Health Office,

County File Number 41-4-35

Date Filed 4-21-41

DELETED
[illegible]

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.....

Licensed Embalmer No.....

P. O. Address.....

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.