

FILED MAY 13 1941

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 358

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 0 (Specify whether
In this community 0 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Bois D'Arc
(If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 27 day
year 1941 hour 4:10 minute _____ A.M.

21. I hereby certify that I attended the deceased from
April 24, 1941, to April 27, 1941;
that I last saw her alive on Apr 27, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Diabetes mellitus 20

Due to Bronchopneumonia 61 72 hrs

Due to Arteriosclerosis

Other conditions Swelling of toe 4 wks

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? _____

(Specify type of place) _____

While at work _____ (e) Means of injury _____

Signature Robert Glynn (M. D. or other) MD

Address Springfield, Mo Date signed _____

3. (a) PRINT FULL NAME Sarah Magill

3. (b) If veteran, name war None 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 James Magill 6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased May 5, 1862
(Month) (Day) (Year)

8. AGE: Years 78 Months 11 Days 22
If less than one day hr. _____ min. _____

9. Birthplace Greene County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation In Home

11. Industry or business _____

12. Name Josiah J. West

13. Birthplace Unknown Tennessee
(City, town, or county) (State or foreign country)

14. Maiden name Angeline Mason

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

16. (a) Informant John West

(b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof 4/28/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prospect Cemetery, Bois D'Arc

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 4-28-41 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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..... *Ed Nothey*

Licensed Embalmer No..... *1767*

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.