

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25168

Registration District No. 318

Primary Registration District No. 5440

Registrar's No. 567

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "URBAN" and name of township) 13 (Campbell) Twp
(c) Name of hospital or institution:
Route # 7
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 10 years
years, months or days

3. (a) PRINT FULL NAME EVA MAY HASSLER

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 Married

6. (b) Name of husband or wife Ora Hassler 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased April 22 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>2</u>	<u>19</u>hr.min.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Joseph Foller

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

14. Maiden name Ragnah Ross

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

16. (a) Informant Ora Hassler

(b) Address Springfield Mo Route # 7

17. (a) Removal (b) Date thereof July 12 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Acosta, Mo.

18. (a) Signature of funeral director Werner

(b) Address Springfield, Mo.

19. (a) 7-12-41 (b) W.E. Handley
(Date received local registrar) (Registrar's signature)

984 (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Route # 7
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11
year 1941 hour 7 minute A M.

21. I hereby certify that I attended the deceased from June 30, 1941, to July 11, 1941,
that I last saw her alive on June 30, 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Insufficiency
Due to Mitral Stenosis

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? _____

While at work? _____ (Specify type of place) (a) Means of injury _____
Signature Letitia B. Webb (M. D. or other) _____
Address Springfield, Mo. Date signed 7-11-41

Duration
3 years
30 years
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

NOV 19 1948

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.....
Self....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

R. H. Thorne

Licensed Embalmer No.....

3681

P. O. Address.....

Springfield, Ma

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.

X