DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

SEP 15 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28299

Registration District No. 318 | Primary Registration District No. 2001 | Registrar's No. 645

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: CITY HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community: D

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.: 420 W. Walnut St (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: BESSIE FRANCES GRUENDLER

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: WALTER GRUENDLER

6. (c) Age of husband or wife if alive: 50 years

7. Birth date of deceased: Dec (Month) 25 (Day) 1891 (Year)

8. AGE: Years 149 | Months 7 | Days 14 | If less than one day ..... hr. ..... min.

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

10. Usual occupation: House wife

11. Industry or business: In home

MOTHER FATHER

12. Name: Jake L. Gonner

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

14. Maiden name: Martha Smith

15. Birthplace: Polk Co (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: Walter F. Gruendler

(b) Address: Springfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-11-41 (Month) (Day) (Year)

(c) Place: burial or cremation: Greenlawn

18. (a) Signature of funeral director: J. W. Klingner & Co

(b) Address: Springfield Mo.

19. (a) 8-11-41 (Date received local registrar) (b) W. E. Handley M.D. (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug day: 9 year: 1941 hour: 5 minute: 30 P.M.

21. I hereby certify that I attended the deceased from July 19 41 to Aug 9 19 41 and that I last saw him alive on Aug 9 19 41 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: General Toxemia Intestinal Obstruction due to	
Due to: Annular Carcinoma of Sigmoid	1½ years
Due to:	
Other conditions (Include pregnancy within 3 months of death): Annular growth of Sigmoid	

Major findings: Of operations: Producing almost complete obstruction. Chronic Salpingitis

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)

(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

23. Signature: Newton Wakeman (M. D. or other) Date signed: 8-11-41

Address: Springfield, Mo.

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 Ogle Sloan Jr.

Licensed Embalmer No. 4176

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
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State File No. 28299

Registration District No. 318 Primary Registration District No. 2001 Registrar's No.

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: City Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Bessie F. Gruendler
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: M-
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Dec 25 1891 (Month) (Day) (Year)
8. AGE: Years Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operation: producing almost complete obstruction
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)
(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

23. Signature: Newton Wakeman (M. D. or other)
Address: Springfield, Mo. Date signed 10-7-41

SUPPLEMENTARY 25:1

Springfield no.