No. 2
-1-4-41
5-17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILLED OCT 14 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31574

Registration District No. 318 Primary Registration District No. 2001 Registrar's No. 774

1. PLACE OF DEATH:

(a) County GREENE;

(b) City or town Springfield City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1109 N. KLAY AVE.
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 35

(c) City or town Springfield 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1109 N. Clay 6
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME ROSE L. BAER.

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 WIDOW

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased Sep. 10 (Month) 1861 (Day) (Year)

8. AGE: Years 80 Months 0 Days 17 If less than one day ..... hr. ..... min.

9. Birthplace Griggsville (City, town, or county) Ind. (State or foreign country)

10. Usual occupation House Wife

11. Industry or business House Work in own home

FATHER
12. Name Batholome Hoback
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Mrs Harold G. Jones
(b) Address 1109 N. Clay, Springfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep 29-1941 (Month) (Day) (Year)
(c) Place: burial or cremation East Lawn

18. (a) Signature of funeral director J. W. Klingner & Co
(b) Address Springfield Mo.

19. (a) 9-29-41 (Date received local registrar) (b) W. E. Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sep day 27 year 1941 hour 9 minute 50 P. M.

21. I hereby certify that I attended the deceased from Sept 14, 1941, to Sep. 27, 1941; that I last saw her alive on Sept. 24, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute entero-colitis	
Due to bacterial infection	2 wks
Due to	
Other conditions Arterio-sclerosis (Include pregnancy within 3 months of death)	7
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 .....

23. Signature Arthur O. Knapp (M.D. or other) MD.

Address 450 N. E. Cavil Date signed 9/28-41

(Licensed Embalmer's Statement on Reverse Side)

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 Roy A. Bauni

Licensed Embalmer No. 1763

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.