

No. 2  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

17976

State File No. \_\_\_\_\_

FILED JUN 10 1942  
318

Registration District No. \_\_\_\_\_

Primary Registration District No. 2001

Registrar's No. 355

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: Burge Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 hrs (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Glenda Amelia Hales

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced, single

6. (b) Name of husband or wife Inf. 6. (c) Age of husband or wife if alive X X years

7. Birth date of deceased Oct 1 1941  
(Month) (Day) (Year)

8. AGE: Years 1 Months 7 Days 4 If less than one day hr. min.

9. Birthplace Jola, Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Glenn Hales

13. Birthplace Jola, Kansas  
(City, town, or county) (State or foreign country)

14. Maiden name Anderson's Folk

15. Birthplace Uniontown, Kansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Margaret Folk

(b) Address 813 9th St. Monett Mo

17. (a) Burial (b) Date thereof 5-7-1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Monett, Mo

18. (a) Signature of funeral director Callaway, Pop

(b) Address Monett, Mo

19. (a) 5-7-42 (b) W.S. Handley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Allen

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5 year 1942 hour 10 minute 50 A. M.

21. I hereby certify that I attended the deceased from May 5, 1942, to May 5, 1942, that I last saw her alive on May 5, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to \_\_\_\_\_

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)

(b) Means of injury D

23. Signature Frank Allen (M. D. or other) MP

Address Monett, Mo Date signed 5/7/42

Physician

Underline the cause to which death should be charged statistically.

784

**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 Phyllis Colleway  
Licensed Embalmer No. 2066  
P. O. Address smoeth St

**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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 17976

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. ....

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:  
(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)

3. (a) PRINT FULL NAME Glenda A. Hales

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 S

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Oct 1 1941  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 7 Days \_\_\_\_\_  
(If less than one day \_\_\_\_\_ min.)

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry of 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day \_\_\_\_\_  
Year 1942 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ live on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions None 107  
(Include pregnancy within 3 months of death)

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature Frank Ken MP (M.D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

