DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21220

FILED JUL 16 1942

Registration District No. 2001 Primary Registration District No. 2001 Registrar's No. 463

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

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: City Hosp. D
(If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield 2
(If outside city or town limits, write "RURAL") 6

(d) Street No. 722 W Olive
(If rural, give location) no

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

If yes, name country

3. (a) PRINT FULL NAME Mary Ida Nutter

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Fm 1

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Joseph Nutter

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Feb (Month) 24 (Day) 1876

8. AGE: Years ✓ 66 Months 3 Days 27 If less than one day hr. min.

9. Birthplace Green. Briar (City, town, or county) W. Va. 1 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Taylor HaLL
13. Birthplace unknown (City, town, or county) W Va 1 (State or foreign country)

MOTHER
14. Maiden name Sarah E. Barnett
15. Birthplace Unknown (City, town, or county) W. Va 1 (State or foreign country)

16. (a) Informant Joseph Nutter
(b) Address 722 W. Olive

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24 (Month) (Day) (Year)
(c) Place: burial or cremation Hazelwood Cemetery

18. (a) Signature of funeral director Dunn Funeral Home
(b) Address Springfield Mo

19. (a) 6-22-42 (Date received local registrar) (b) [illegible] (Registrar's signature)

984 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21 th year 1942 hour I minute A M.

21. I hereby certify that I attended the deceased from 6-8, 1942 to 6-21, 1942 that I last saw her alive on 6-20, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Embolism	1½ days
Due to: Followed	
Due to: pelvic Surgery	9 days
Due to:	
Other conditions (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? (Specify type of place)
While at work? (e) Means of injury

23. Signature W. Roland Lanham (M. D. or other) MD
Address Springfield Mo. Date signed 6/22/42

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 Lawrence R. Hall

Licensed Embalmer No. 2784

P. O. Address Springfield Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit 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
>1 X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21220

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 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: Mary J. Nutter
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: Feb (Month) 24 (Day) 1876 (Year)
8. AGE: Years 66 Months 3 Days 28 If less than one day hr. min.
9. Birthplace (City, town, or county) Wva (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 June 24 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pelvic surgery	
Due to: Malignancy of uterus	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 48 h	
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 W. Roland Langston (M. D. or other) MD
Address Springfield Mo Date signed

SUPPLEMENTARY