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6

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

1. PLACE OF DEATH:

GREENE

(a) County.....
(b) City or town..... Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... 10 days
(Specify whether
In this community..... 13 years
years, months or days)

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..... 427 E. Madison
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Martha Cochran

3. (b) If veteran, name war..... No 3. (c) Social Security No..... No

20. DATE OF DEATH: Month..... Oct day..... 13th,
year..... 1942 hour..... 7:30 minute..... a M.

21. I hereby certify that I attended the deceased from..... October 6th
....., 1942 to..... Oct 13th....., 1942
that I last saw her alive on..... Oct 12th....., 1942
and that death occurred on the date and hour stated above.

Immediate cause of death..... Bronchopneumonia Duration..... 5 days

4. Sex..... Female / race..... White 5. Color or
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..... April 4th 1871
(Month) (Day) (Year)

8. AGE: Years..... 71, Months..... 6 Days..... 9 If less than one day
..... hr. min.

9. Birthplace..... Greenway Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... John Leeth
13. Birthplace..... Tenn.
(City, town, or county) (State or foreign country)

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

16. (a) Informant..... Mrs. Cecil Taylor
(b) Address..... Springfield, Mo.

17. (a) Removal (b) Date thereof..... Oct 14 42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... Greenway Ark.

18. (a) Signature of funeral director..... H. H. Lohmeyer
(b) Address..... Springfield, Mo.

19. (a) 10-14-42 (b) S. W. Handy
(Date received local registrar) (Registrar's signature)

Due to.....

Due to..... 107

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy..... Bronchopneumonia

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) (e) Means of injury.....

23. Signature..... Paula Kay M.D. (M. D. or other)
Address..... Springfield Mo Date signed..... 10/13/42

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.....

Walter E. Daniels

Licensed Embalmer No. *3808*

P. O. Address.....

Springfield, Mo

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