S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

TMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 11 1948

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

40733

State File No.

Registration District No. Primary Registration District No. 2000 Registrar's No. 857

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 1537 N. GRANT /
(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 59 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39

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

(d) Street No. 1537 N. Grant
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME MARY ELLEN CASE

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 July (Month) 17 (Day) 1863 (Year)

8. AGE: Years 79 Months 4 Days 14 If less than one day hr. min.

9. Birthplace Manchester (City, town, or county) England (State or foreign country) 4

10. Usual occupation House wife

11. Industry or business In home

MOTHER FATHER

12. Name John Hayes

13. Birthplace Unknown (City, town, or county) England (State or foreign country) 4

14. Maiden name Unknown

15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country) 9

16. (a) Informant Mrs. R. J. Ryan

(b) Address Tulsa Okla

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4-1942 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

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

(b) Address Springfield Mo.

19. (a) 12-8-42 (Date received local registrar) (b) B. M. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 1st year 1942 hour 8 minute 25 A. M.

21. I hereby certify that I attended the deceased from June 15 1937 to Dec 1 1942 that I last saw her alive on Nov 30 1942 and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerosis — Duration 5 yrs.

Due to

Due to Senility

Other conditions Hemorrhage from lung 4 dy.
(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. T. Walsh (M. D. or other)

Address Springfield Mo. Date signed 12/1/42

(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 J B Klingner

Licensed Embalmer No. 3358

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.

S. No. 2B-
M—8-21-41
I 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. 40733

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 857

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: 5-9 yrs

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.: 1537 No Grant
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Mary E Case

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: Wid

6. (b) Name of husband or wife:

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

7. Birth date of deceased: July 17 — 1863
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 12 If less than one day: hr. min.

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

10. Usual occupation:

11. Industry or business:

MOTHER FATHER

12. Name: John Hayes

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

14. Maiden name: unk

15. Birthplace: unk
(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: Dec Day: 1
year: 1942 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.

Immediate cause of death: Pulmonary sclerosis

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death): Hemorrhage from lungs

Major findings:
Of operations: lung

Of autopsy: 97

Duration

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. T. Walsh (M. D. or other)
Address: Springfield Mo Date signed: 4/26/43

SUPPLEMENTARY