

FILED MAR 8 1943

Registration District No. 126

Primary Registration District No. 3460

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Rural Route 1

(c) Name of hospital or institution Rural Route 1 General  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_

In this community 17 miles - township  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn

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

(d) Street No. Rural Route 1  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME AMANDA SMITH

(b) If veteran,  name war \_\_\_\_\_

(c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 12  
year 1943 hour 7:15 minute A.M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced, widow

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

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

7. Birth date of deceased: March 5 - 1863  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1 - 3 - 1943 to 2 - 12 - 1943  
that I last saw her alive on 2 - 5 - 1943  
and that death occurred on the date and hour stated above.

8. AGE: Years 79 Months 11 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Asthma & Bronchial Infection

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

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

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

Other conditions (Include pregnancy within 3 months of death) 106C

10. Usual occupation Housewife

11. Industry or business In Home

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown Unknown

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

14. Maiden name Unknown Unknown

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Myrtle Spae

(b) Address Route 1E Spfld.

17. (a) Burial (b) Date thereof 12-15-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation Greenwood

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

(b) Address Springfield, Mo.

19. (a) 1943 (b) W. J. ... & Co  
(Date received local registrar) (Registrar's signature)

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

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

23. Signature W. J. ... (M. D. \_\_\_\_\_)

Address Springfield Mo Date signed 2-13-43

1230

RECEIVED

Greene County Health Office

County File Number 43-3 20

Date Filed 3/4/43

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 W. H. Hodges

Licensed Embalmer No. 407

P. O. Address Springfield

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.

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