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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 28 1943 28

Registration District No. ~~313~~

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Dr Robt Williams
Landing

State File No. 21347

Primary Registration District No. 2000

Registrar's No. 475

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2101 West Lincoln, /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 8 Months
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 39

(a) State Missouri (b) County Greene 2

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

(d) Street No. 2101 W.Lincoln
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Sarah Johnson

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F M

5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Unk.

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

7. Birth date of deceased February (Month) 14 (Day) 1866 (Year)

8. AGE:

Years	Months	Days	If less than one day
✓ 77	3	25	hr. min.

9. Birthplace Douglas County (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) Unk. 9 (State or foreign country)

MOTHER
14. Maiden name ~~Unknown~~ Jane Clinton
15. Birthplace ~~Unknown~~ Unk (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant Eva M.Johnson

(b) Address 2101 W.Lincoln, Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 - 11 - 43 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Grove Mo

18. (a) Signature of funeral director Dunn Funeral Home

(b) Address Springfield, Mo.

19. (a) 6-21-43 (Date received local registrar) (b) Dr W E Hardley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9
year 1943 hour 3:45 minute A.M. M.

21. I hereby certify that I attended the deceased from June 8, 1943, to June 8, 1943;
that I last saw her alive on June 8, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration 10 hrs

Due to ✓

Due to ✓

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

Major findings:
Of operations no

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) None

(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 Robert T Williams (M.D. or other) 6/9/43

Address Springfield Mo Date signed

924

(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 Clarence D McCalkon

Licensed Embalmer No. 2891

P. O. Address.....

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.