

S. No. 2
DM-2-43
5-1-1939
I 233597

28287

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 10 1943

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 610 B

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

(d) Length of stay: In hospital or institution 5 Weeks
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Christian

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

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

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

3. (a) PRINT FULL NAME Nona Ann Rhodes

3. (b) If veteran, name war no

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

7. Birth date of deceased Jan. 12, 1893
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>✓ 50</u>	<u>6</u>	<u>17</u>	hr. _____ min.

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

10. Usual occupation housewife

11. Industry or business _____

12. Name Johnny McCafferty

13. Birthplace unk. Tenn. 1
(City, town, or county) (State or foreign country)

14. Maiden name Callie D. Faught

15. Birthplace unk. Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Evelyn Shelton

(b) Address Ozark, Mo.

17. (a) burial (b) Date thereof July 30, 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McConnell cem.

18. (a) Signature of funeral director T.W. Maples

(b) Address Clever, Mo.

19. (a) 8-27-43 (b) O. W. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July, day 29th, year 1943, hour 6 A. minute _____ M.

21. I hereby certify that I attended the deceased from Jan 41 to July 29, 1943; that I last saw her alive on July 28, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of cervix uteri

Due to _____

Due to _____

Other conditions H&F
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 Robert Glynn (M. D. or other) O. W. Handley
Address Springfield, Mo. Date signed 8/4/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

39
2
6

MOTHER FATHER

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.W. Maples*
Licensed Embalmer No. *2985-*
P. O. Address *Clare 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.

*