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

Dr. Spears
Billings, Mo. 42268

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 11 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 122

Primary Registration District No. 4201

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Republic
(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)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Republic 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

3. (a) PRINT FULL NAME Mary Handy

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 21
year 1943 hour 9 minute 30 a.m.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Dec. 12, 1851
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 15, 1943, to Dec 20, 1943; that I last saw her alive on Dec 20, 1943; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

92 0 8 hr. min.

Immediate cause of death Hypostatic Pneumonia 7 days

Due to senility

Due to _____

9. Birthplace Clark County Illinois
(City, town, or county) (State or foreign country)

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

Major findings: _____

Of operations _____

Of autopsy _____

10. Usual occupation _____

11. Industry or business _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Cypress Willard

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

14. Maiden name Unknown

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

16. (a) Informant M.D. Handy

(b) Address Linden, Mo.

17. (a) Burial (b) Date thereof Dec. 23, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Linden, Mo.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

(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 ☉

19. (a) Dec. 23, 1943 (b) Glorious Britain
(Date received local registrar) (Registrar's signature)

23. Signature Charles Spears (M. D. or other) MD
Address Billings, Missouri Date signed 12-22-43

1241

RECEIVED

Greene County Health Office,

County File Number 44-1-9

Date Filed 1-10-44

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 Hamilton

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Republic
(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 _____)

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

3. (a) PRINT FULL NAME Mary Handy

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

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased Dec. 12 1851
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 21
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him/her alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Hypostatic Pneumonia 7 da.
Bronchial pneumonia 7 da.

Due to _____

Due to Senility

Other conditions (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 Charles A. Spears (M. D. or other) MD

Address Billings, Mo. Date signed 1-18-44

SUPPLEMENTARY

MOTHER, FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

S-42268