

FILED JAN 25 1944

State File No.

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 31

1. PLACE OF DEATH:

(a) County **CRIDE**
Springfield
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. John's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days** (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**
(c) City or town **Springfield** (If outside city or town limits, write "RURAL")
(d) Street No. **1003 W. State St.** (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Alice. Briscoe**

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

4. Sex **F.** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **Hub.** 6. (c) Age of husband or wife if alive **Dec. 23** years

7. Birth date of deceased **October 2nd 1866**
(Month) (Day) (Year)

8. AGE: Years **77** **3** months Days **-** If less than one day
hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Stahn Putman**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Mrs. B. L. Hurry**

(b) Address **1003 W. State St. Spfld.**

17. (a) **Removal** (b) Date thereof **1-10-1944**
(Month) (Day) (Year)

(c) Place: burial or cremation **Burial**

18. (a) Signature of funeral director **W. W. Henders**

(b) Address **Springfield Mo**

19. (a) **1-10-44** (b) **W. W. Henders**
(Date received local registrar) (Registrar's signature)

9062 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **1** day **9**
year **1944** hour **9** minute **15 a.m.**

21. I hereby certify that I attended the deceased from **Dec 23**, 19**43**, to **Jan 9**, 19**44**
that I last saw her alive on **Jan 9**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**
follows fracture of hip
Due to **She has been in my care**
recent for past year
Due to _____

Duration
2 Wk

Other conditions (Include pregnancy within 3 months of death) **186 a**

Major findings: Of operations _____

Of autopsy **None**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

(b) Date of occurrence **Dec 23 - 43**

(c) Where did injury occur? **Springfield Greene Missouri**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In her home

While at work? **no** (Specify type of place) (e) Means of injury **fall**

23. Signature **Robert Williams** (M. D. or other)

Address **Springfield Mo** Date signed **9-44**

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

13300

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 *Ray A. Leamm*
Licensed Embalmer No. *1763*
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.