DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 27 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11008

Registration District No. 128 | Primary Registration District No. 2000 | Registrar's No. 213

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

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: Burge Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: 59 day

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.: 1147 Drummond (If rural, give location)

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

3. (a) PRINT FULL NAME: Isabel Richie Mayes

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: female

5. Color or race: White

6. (a) Single, widowed, divorced, married: Widowed

6. (b) Name of husband or wife: David Mayes

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

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

8. AGE: Years 77 | Months 8 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace: Malden (City, town, or county) Mass. (State or foreign country)

10. Usual occupation: H.W.

11. Industry or business: Housework

MOTHER FATHER

12. Name: Elwood Baldwin

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

MOTHER

14. Maiden name: Ritchie

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

16. (a) Informant: Mrs. Helen D. Mayes

(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-4-44 (Month) (Day) (Year)

(c) Place: burial or cremation: Maple Park

18. (a) Signature of funeral director: Ahmann-Lemmon F. Home

(b) Address: Springfield Mo

19. (a) 3-4-44 (Date received local registrar) (b) W. S. Hawkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2 year 1944 hour 9 minute 45 p.m.

21. I hereby certify that I attended the deceased from Dec 28 1943 to Mch 2 1944 that I last saw him alive on Mch 2 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial insufficiency / Bronchopneumonia

Due to: Senility + Spinal

Due to: Scoliosis + Kyphosis

Other conditions (Include pregnancy within 3 months of death): Diabetes L. Cumbus

Major findings: Of operations: Gallbladder Dec. 27, 1943

Of autopsy: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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) 133

(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: James E. Evans (M. D. or other)

Address: Spfd, Mo. Date signed 3-3-44

(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 Lewis G Scharpf

Licensed Embalmer No. 3802

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
0M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. FILED April 16

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 213

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:
(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)

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

3. (a) PRINT FULL NAME Isabel R. Mayer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

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

8. AGE: Years 77 Months 8 Days 8 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 2
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

186a
18

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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

(b) Date of occurrence DEC. 28, 1943

(c) Where did injury occur? SPRINGFIELD GREENE, MO.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
~~Home~~, Fell in home
(Specify type of place)

While at work? (e) Means of injury

23. Signature James E. Dewey (M. D. or other)

Address MEDICAL ARTS BLDG. Date signed 4-6-44

11008