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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 27 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11035

Registration District No. ~~35~~ 128 Primary Registration District No. 2000 Registrar's No. 233

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

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield Missouri (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 12 days - 20 hrs (Specify whether years, months or days)

In this community 12 days - 20 hrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ozark 77

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

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

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

If yes, name country 1

3. (a) PRINT FULL NAME Charlotte Jane St. John

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 Single

6. (b) Name of husband or wife None

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

7. Birth date of deceased August (Month) 14 (Day) 1938 (Year)

8. AGE: Years 5 Months 6 Days 25 If less than one day hr. min.

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

10. Usual occupation Child

11. Industry or business

FATHER
12. Name Jamie William St. John
13. Birthplace Sparta (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Mary Lou Clout
15. Birthplace Marshfield (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Jamie William St. John

(b) Address Gainesville, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-44 (Month) (Day) (Year)

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

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

(b) Address Ava, Missouri

19. (a) 3-11-44 (Date received local registrar) (b) S. M. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 9 year 1944 hour 1 minute 35 P.M.

21. I hereby certify that I attended the deceased from 2-14, 1944 to 3-9, 1944 that I last saw her alive on 3-9-44, 19 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Rheumatic Pancarditis	1 mo
Due to Rheumatic fever	1½ mo
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 58d
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)

(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 Leeba Beseek (M. D. or other)

Address Springfield, Mo. Date signed 3-9-44

(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 W. B. Hutchinson

Licensed Embalmer No. 3431

P. O. Address Ava 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.