

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 277724
Registrar's No. _____

FILED SEP 6 1944
SEP 6 1944 318-128
Registration District No. _____

Primary Registration District No. 2001D

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:
Springfield Baptist Hospital
(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

3. (a) PRINT FULL NAME Mary M. Buell

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 29 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>11</u>	<u>2</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name T. J. Watt
13. Birthplace Ohio
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Jerusha Parker
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ollie Wilson
(b) Address Green Forest, Ark.
17. (a) Burial (b) Date thereof Sept. 1, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grin, Green Forest
18. (a) Signature of funeral director Wilson Funeral Home
(b) Address Berryville, Ark.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Carroll 999
(c) City or town Green Forest 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 2
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 31st
year 1944 hour 3 minute 30 P. M.
21. I hereby certify that I attended the deceased from Aug 29, 1944, to Aug 31, 1944
that I last saw her alive on Aug 30, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 2 1/2 hr

Due to arterio-sclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) 946

Major findings:
Of operations _____
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? _____

23. Signature Guy D. Callaway (M. D. or other) _____
Address Springfield Mo Date signed 8/31/44
While at work? _____ (Specify type of place)
(e) Means of injury _____

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.....

Floyd E. Carothers

Licensed Embalmer No.....

P. O. Address.....

Berryville Ark

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.

Registration District No. 128

Primary Registration District No. 2000

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.....
(Specify whether

In this community.....
years, months or days)

3. (a) PRINT FULL NAME Mary M. Buell

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 W

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

7. Birth date of deceased Sept. 29
(Month) (Day) (Year)

8. AGE: Years 79 Months 1 Days 10 If less than one day, min.

9. Birthplace Ohio
(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) 1-16-46 (b) Dr. H. E. Handley
(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 Aug Year 1944 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....

that I last saw him..... 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.....

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..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

27724