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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr. Feller

State File No. 34238

FILED NOV. 6 1928

Registration District No. 1928 Primary Registration District No. 2000 Registrar's No. 860

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: 2024 N. Lyon (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) 32 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

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

(d) Street No. 2024 N. Lyon (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Mary Jane Hancock

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife John R. Hancock

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

7. Birth date of deceased March (Month) 10, (Day) 1887 (Year)

8. AGE: Years 57 Months 7 Days 20 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

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

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

16. (a) Informant John R. Hancock

(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/44 (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

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

(b) Address Springfield, Mo.

19. (a) 10-31-44 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 30 year 1944 hour 4 minute 30 p.M.

21. I hereby certify that I attended the deceased from 10-29- 1944 to 10/30/ 1944 that I last saw her alive on 10/29/ 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Epilepsy Spasm with Cerebral Hemorrhage — Duration

Due to Duration 24 hrs — 10/29 to

Due to — 10/30-44

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 83a

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 C E Feller (M. D. ~~or other~~)

Address Springfield Mo Date signed 10/31/44

(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 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.