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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33-234260
State File No. _____
Registrar's No. 823

FILED NOV 6 1944
Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution: Springfield Baptist Hospital
(d) Length of stay: In hospital or institution 22 days
In this community 22 days years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Christian
(c) City or town Bruner
(d) Street No. 710
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Rachal Lee McHaffie
3. (b) If veteran, name war no
3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 16
year 1944 hour 12 minute 47 A.M.
21. I hereby certify that I attended the deceased from Oct. 14
1944, to Oct. 16 1944
that I last saw her alive on Oct 16 1944
and that death occurred on the date and hour stated above.

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: July 19 1939
(Month) (Day) (Year)

Immediate cause of death: Prolonged fever of unknown etiology
Duration 6 wks.

8. AGE: Years 5 Months 2 Days 27
If less than one day hr. min.

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

9. Birthplace Bruner Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation child

MOTHER FATHER
11. Industry or business _____
12. Name Hobson McHaffie
13. Birthplace Bruner Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Dr. Evelyn Drake
15. Birthplace Bruner Missouri
(City, town, or county) (State or foreign country)

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? _____
While at work? _____ (Specify type of place)
Means of injury _____

16. (a) Informant Mr. Hobson McHaffie
(b) Address Bruner, 710 St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19 44
(Month) (Day) (Year)
(c) Place: burial or cremation McHaffie, Cem.
18. (a) Signature of funeral director Otto R. Anderson
(b) Address Sparta Mo
19. (a) 10-19-44 (Date received local registrar) (b) Dr. W. H. Hagedley (Registrar's signature)

23. Signature Thomas S. Harris (M. D. or other) MD
Address Medical Arts Building Date signed 10/16/44

(Licensed Embalmer's Statement on Reverse Side) Springfield, Mo.

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

REMOVED
APPROPRIATE

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..... *T. B. Chaffin*.....

Licensed Embalmer No. *2192*.....

P. O. Address *Ozark, 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.

X

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 170Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 823

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)

(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 Rachel Lee Mc Haffie

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 S

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

7. Birth date of deceased July 19 1943
(Month) (Day) (Year)8. AGE: Years 5 Months 2 Days 14 If less than one day _____ hr. _____ min.9. Birthplace _____ (City, town, or county) (State or foreign country) MO.

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) _____ (b) _____
(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 Oct 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 changed from a
unbroken etiology
(Probable) Rocky Mountain
Spotted FeverOther conditions _____
(Include pregnancy within 3 months of death) 39°

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? _____

While at work _____ (Specify type of place)
(c) Means of injury _____23. Signature Thomas S. Harris, M.D.Address Springfield, Mo. Date signed 11-15-44

Duration

low

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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

SUPPLEMENTAL INFORMATION REQUESTED

STANDARD CERTIFICATE OF DEATH
ISSUED TO FACSIMILE DEPARTMENTS

RECORDED TO THE VITAL
200 1000 1000

THOMAS S. HARRIS, M. D.
332-340 Medical Arts Building
Springfield, Missouri
15 November 1944

Dr. James Stewart, Special Agent,
Bureau of the Census,
State Board of Health,
Jefferson Dity, Missouri.

Dear Sir:

I regret that this certificate had to be returned to me. The diagnosis was not definitely established before death, but the chief possibilities lay between Rocky Mountain Spotted Fever and Typhus Fever. I have entered the former as the probably cause of death on the enclosed supplementary certificate, as the symptoms and findings suggested it more than the latter.

However, I wish to emphasize that the correct diagnosis was not established, and this certificate will be statistically valueless.

Very truly yours,

Thomas S. Harris, M.D.

Thomas S. Harris, M. D.

34260

RECEIVED BY THE VITAL DEPARTMENT OF THE STATE OF MISSOURI