

S. No. 2  
M-5-42  
v. 5-17-39  
I X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 25 1945

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2193

FILED JAN 25 1945  
Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 8

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

39  
2  
6

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:  
521 E. CALHOUN  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO. (b) County GREENE 29  
(c) City or town SPRINGFIELD  
(If outside city or town limits, write "RURAL")  
(d) Street No. 521 E. CALHOUN  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME MYRTLE JANE DOUGLAS  
3. (b) If veteran, name war NONE  
3. (c) Social Security No. 494-20-4958

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month JAN. day 2  
year 1945 hour 6 minute 15 A.M.

4. Sex FEMALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife DAVID LESTER DOUGLAS  
6. (c) Age of husband or wife if alive 50 years  
7. Birth date of deceased MAY 2, 1898  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Unattended by physician 1945 to 1945 that I last saw him alive on 1945 and that death occurred on the date and hour stated above.

8. AGE: Years 46 Months 8 Days 0 If less than one day hr. min.

Immediate cause of death probably coronary occlusion  
Duration

9. Birthplace UNK. ARK.  
(City, town, or county) (State or foreign country)  
10. Usual occupation HOUSE WIFE

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

11. Industry or business AT HOME  
12. Name SAM MURPHY  
13. Birthplace UNK. UNK.  
(City, town, or county) (State or foreign country)  
14. Maiden name NANCY JANE STEWART  
15. Birthplace UNK. UNK.  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant David Lester Douglas  
(b) Address Springfield Mo.  
17. (a) Burial (b) Date thereof Jan. 4, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Green Lawn Cem  
18. (a) Signature of funeral director W. Klingner & Co.  
(b) Address Springfield, MO.  
19. (a) 1-4-45 (b) W. E. Haudley  
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury  
23. Signature W. E. Haudley Local Registrar (M. D. or other)  
Address Springfield, Mo. Date signed 1/4/45

MAY 27 1949

FEB 1 1945

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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..... *Ogden Stone Jr.* .....  
Licensed Embalmer No. *4196* .....  
P. O. Address *Springfield* .....

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*