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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 26 1945

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 402a

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 1 week
(Specify whether
 In this community For 1 year
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Christian
 (c) City or town rural
(If outside city or town limits, write "RURAL")
 (d) Street No. Cleaver - Route 1.
(If rural, give location)
 (e) Citizen of foreign country? no 1 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mrs. May Maples

3. (b) If veteran, name war None 3. (c) Social Security No. none

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Herbert Maples 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Aug. 24 - 1891
(Month) (Day) (Year)

8. AGE: Years 53 Months 8 Days 21 If less than one day
hr. min.

9. Birthplace Mammouth Springs Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

12. Name E. F. ~~Franklin~~ Bailey

13. Birthplace UNK. Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Josephine Young

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Herbert Maples
 (b) Address Cleaver - Mo. R#1.

17. (a) Burial (b) Date thereof 5-18-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Trazier Chapel

18. (a) Signature of funeral director J. W. Maples
 (b) Address Cleaver - Mo.
 19. (a) 5-20-45 (b) Dr. W. S. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15th
 year 1945 hour 1:00 minute A. M.

21. I hereby certify that I attended the deceased from 5-8 1945 to 5-15 1945;
 that I last saw h. l. M. alive on 5-14 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of uterus
 Due to Post operation hemorrhage

Due to Operation shock
 Other conditions 4 8 lb
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of uterus
 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? _____ (Specify type of place)
 (c) Means of injury _____

23. Signature Robert S. ... (M. D. or other) ...
 Address ... Date signed ...

Duration

5R
3 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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..... *JW Maples*

Licensed Embalmer No. *2985*

P. O. Address *Clever 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.