Dr Musick

. S. No. 2
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ev. 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. 30603

FILED SEP 25 1945

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 724

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

9
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: 631 S. Grant
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 39
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No. 631 S. Grant 6
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Cora Lee Sawyer
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 Widowed
6. (b) Name of husband or wife Unk.
6. (c) Age of husband or wife if alive Dec years
7. Birth date of deceased Oct. (Month) 25, (Day) 1873 (Year)

8. AGE: Years 71 Months 10 Days 17 If less than one day hr. min.

9. Birthplace UNK. (City, town, or county) UNK. 9 (State or foreign country)
10. Usual occupation Unk. None
11. Industry or business
FATHER
12. Name UNK.
13. Birthplace UNK. (City, town, or county) UNK. 9 (State or foreign country)
MOTHER
14. Maiden name UNK.
15. Birthplace UNK. (City, town, or county) UNK. (State or foreign country)
16. (a) Informant Mrs. Leonard Johns
(b) Address 631 S. Grant, Sp'fd
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-45 (Month) (Day) (Year)
(c) Place: burial or cremation Aurora, Mo.
18. (a) Signature of funeral director W. L. Dunn
(b) Address Springfield, Mo.
19. (a) 9-15-45 (Date received local registrar) (b) B W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12 year 1945 hour 9:00 minute P. M.
21. I hereby certify that I attended the deceased from Aug. 10, 1945, to Sept. 12, 1945 that I last saw her alive on Sept. 11, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcimoma-Colon	Don't know
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 46

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) Dne
(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 J. Dmusick MD (M. D. or other)
Address Springfield, Mo. Date signed 9,13,45

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(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 C. D. McCracken

Licensed Embalmer No. 28-91

P. O. Address .....

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.