V. S. No. 2
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Rev. 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. 30616

FILED SEP 25 1945

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 736

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

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town SPRINGFIELD Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1312 - E - DIVISION 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County GREENE
(c) City or town SPRING FIELD Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 1312 - E - DIVISION
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME EULA MAY WHITFIELD
3. (b) If veteran, name war None
3. (c) Social Security No. unk.
4. Sex Female
5. Color or race NEGRO
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife OWEN WHITFIELD
6. (c) Age of husband or wife if alive unk. years
7. Birth date of deceased SEPT. (Month) 10 (Day) 1885 (Year)

8. AGE: Years	Months	Days	If less than one day
60	0	4	hr. min.

9. Birthplace Scott Co. (City, town, or county) Miss. (State or foreign country)
10. Usual occupation DOMESTIC
11. Industry or business
FATHER 12. Name WM H. BERRY
FATHER 13. Birthplace KEMPER CO. (City, town, or county) Miss. (State or foreign country)
MOTHER 14. Maiden name ROXIE HALTON
MOTHER 15. Birthplace KEMPER Co. (City, town, or county) MISS. (State or foreign country)
16. (a) Informant OWEN WHITFIELD
(b) Address 1312 - E - DIVISION, Spd. Mo.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT-19-45 (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln Memorial
18. (a) Signature of funeral director H. V. Smith
(b) Address 702 N. Jefferson, Spd. Mo.
19. (a) 9-19-45 (Date received local registrar) (b) W. E. Hurley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 14 year 1945 hour 3 minute 0.5 A.M.
21. I hereby certify that I attended the deceased from Sept 13, 1945, to Sept 13, 1945 that I last saw he alive on Sept 13, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations none	
Of autopsy none	

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 R. T. Freeman (M. D. or other)
Address Springfield Mo Date signed 9-15-45

(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 Herbert V Smith

Licensed Embalmer No. 4286

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.