S. No. 2
1—8-43
5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 29 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

33790

State File No.

Registration District No. 128 Primary Registration District No. 5465 Registrar's No. 828

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Rural N. Campbell Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Route #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 6 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town N Campbell Twp Springfield Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Route #1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME GLADYS ROUTH

3. (b) If veteran, name war None

3. (c) Social Security No. UNK.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Clyde Routh

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased Aug. 30 1898
(Month) (Day) (Year)

8. AGE: Years 47 Months 1 Days 15 If less than one day hr. min.

9. Birthplace Dallas Co., Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name S. T. Gower
13. Birthplace Taney Co. Mo. 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Stever
15. Birthplace Dallas Co Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Clyde Routh
(b) Address Springfield Mo.

17. (a) Burial (b) Date thereof Sept 17 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Comfort

18. (a) Signature of funeral director L B Jones
(b) Address Buffalo Mo.

19. (a) 9-17-45 (b) W E Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 15
year 1945 hour 7 minute 15 P.M.

21. I hereby certify that I attended the deceased from Oct. 15, 1945, to Oct 15, 1945
that I last saw her alive on Oct. 15, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of left breast with metastases to internal organs — Duration 1 yr

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 50

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 Arthur D Knapp M.D. or other M.D.
Address 450 1/2 E. Court, Spfd., Mo. Date signed 10-17-45

(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 Leonard B. Jones

Licensed Embalmer No. 2598

P. O. Address Buffalo 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.