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7. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16337
Registrar's No. 449

Registration District No. 128 Primary Registration District No. 2000

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

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution: Springfield Baptist Hospital
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Willie Mae Presley
3. (b) If veteran, name war No. 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 Everett Presley 6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased September 11, 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 8 12 hr. min.

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

10. Usual occupation Housewife
At Home

11. Industry or business
12. Name W. H. Winingar
13. Birthplace UNK. Ind.
14. Maiden name Lucy Howard
15. Birthplace Boone Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Lucy Calvin
(b) Address Columbia, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25, 1946
(Month) (Day) (Year)
(c) Place: burial or cremation Mt. Comfort Cem.

18. (a) Signature of funeral director [Signature]
(b) Address Springfield Mo.
19. (a) 5-25-46 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Greene Polk 54
(c) City or town Brighton
(d) Street No. R. F. D. 1.
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 23
year 1946 hour 3 minute 30 A.M.
21. I hereby certify that I attended the deceased from May 21, 1946 to May 22, 1946
that I last saw her alive on May 22, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of uterus
Due to _____
Due to _____

Other conditions none
(Include pregnancy within 3 months of death)
Major findings:
Of operations [Signature]
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? _____
(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 [Signature] (M. D. or other) M.D.
Address Med. Arts Bldg. Springfield Date signed 5-24-46

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

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.....

Licensed Embalmer No. 4071

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. ' X