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17-39  
X2315

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

23305

State File No. \_\_\_\_\_

FILED AUG 1 1946  
Registration District No. ~~111~~ 128

Primary Registration District No. 200D

Registrar's No. 562

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

1. PLACE OF DEATH: **GREENE**  
 (a) County **Springfield**  
 (b) City or town \_\_\_\_\_  
 (c) Name of hospital or institution: **City Hospital St. John's Hosp**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **0** (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **Greene**  
 (c) City or town **Springfield**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **613 Jones** (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Child of Follie McCarroll**  
 3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**  
 4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Infant**  
 6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive **XX** years  
 7. Birth date of deceased **7-1-46**  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **July** day **1**  
 year **1946** hour **6** minute **30 a.** M.  
 21. I hereby certify that I attended the deceased from **July 1**, 19**46**, to **July 2**, 19**46**  
 that I last saw him alive on **July 1**, 19**46**  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**0 0 0 2 hr. 30 min.**

Immediate cause of death **Prematurity 7 mos.**  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death)  
 Major findings: **159**  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

9. Birthplace **Springfield MO**  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation **Infant**  
 11. Industry or business \_\_\_\_\_  
 12. Name \_\_\_\_\_  
 13. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **Follie McCarroll**  
 15. Birthplace **Emboden Ark.**  
 (City, town, or county) (State or foreign country)  
 16. (a) Informant **Follie McCarroll**  
 (b) Address **613 Jones, SPED.**  
 17. (a) **BURIAL** (b) Date thereof **7-2-46**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **City Cemetery**  
 18. (a) Signature of funeral director **J. H. Smith**  
 (b) Address **702 N. Jefferson**  
 19. (a) **7-5-46** (b) **W. H. Handley**  
 (Date received local registrar) (Registrar's signature)

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) (p) Means of injury  
 23. Signature **Don Selahy** (M. D. or other) **M.D.**  
 Address **Springfield, Mo.** Date signed **7-5-46**

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

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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.....

Licensed Embalmer No.....

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.**