

**FILED** NOV 27 1946  
Registration District No. **128**

Primary Registration District No. **2000**

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: **Burge Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **Dead when admitted**  
(Specify whether years, months or days)

3. (a) PRINT-FULL NAME **Martha Sue Dawson**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **female** 5. Color or race **W.**  
6. (a) Single, widowed, married, divorced **0**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: **Jan. 15 1942**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**4 9 4** hr. min.

9. Birthplace **Monett Mo. R.R. #1**  
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business **none**

MOTHER FATHER {  
12. Name **Wilbur Deles Dawson**  
13. Birthplace **Bethany Mo.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Emma Againe Morlan**  
15. Birthplace **Monett Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **father**  
(b) Address **Monett Mo. R.R. #1**

17. (a) **Funeral** (b) Date thereof **Oct. 25-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Monett, Mo.**

18. (a) Signature of funeral director **L. H. Blankenship**

(b) Address **Monett Mo.**

19. (a) **10-25-46** (b) **W. E. Handley MD.**  
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Barry** **5**  
(c) City or town **Monett Mo. R.R. #1** **0**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **none** (If rural, give location) **0**  
(e) Citizen of foreign country? **no** (Yes or No) **1**  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **22**  
year **1946** hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from **10-22-46**, 19\_\_\_\_, to **10-22-46**, 19\_\_\_\_;  
that I last saw her alive on **10-22-46**, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** Duration **1 day**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions **Rheumatic Fever** **2 mo.**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
ADDITIONAL SUPPLEMENTARY INFORMATION

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury **0**

23. Signature **E. J. Schwarz** (M. D. or other)  
Address **420 Muldler Springfield** Date signed **10-22-46**

**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. H. Blankenship

Licensed Embalmer No. 2397

P. O. Address Summit, 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.

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Registration District No. 128

Primary Registration District No. 2000

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:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Martha S. Dawn

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Jan 18 1918  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 2 Year 1946 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Bronchial Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy 101

Duration \_\_\_\_\_  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. J. Schwartz (M. D. or other) \_\_\_\_\_ Address 420 Ind. Ave. Bldg. Springfield Date signed 11-14-46

SUPPLEMENTARY

MOTHER FATHER

32087

WRITE PLAINLY - USE UNFADING INK

33259