

No. 2
-12-45
-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 782

FILED FEB 14 1947
Registration District No. 28

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
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. John's Hosp. 1)
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 Days
(Specify whether)
 In this community 70 Years
years, months or days

3. (a) PRINT FULL NAME Mary H. Cosby
 3. (b) If veteran, name war No 3. (c) Social Security No. No
 4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Louis J. Cosby 6. (c) Age of husband or wife if alive Dec. years
 7. Birth date of deceased Oct. 25 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>3</u>	<u>9</u>	hr. min.

9. Birthplace Greene County Missouri
(City, town, or county) (State or foreign country)
 10. Usual occupation Home

11. Industry or business _____
 12. Name Benjamin J. Gott
 13. Birthplace McCastin Tenn.
(City, town, or county) (State or foreign country)
 14. Maiden name Amanda C. Gott
 15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. John Schaeffer
 (b) Address Route # 5 Springfield, Mo.
 17. (a) Burial (b) Date thereof 2/7/47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Green lawn

18. (a) Signature of funeral director H.H. Lohmeyer
 (b) Address Springfield, Mo.
 19. (a) 2-6-47 (b) W. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Greene 39
 (c) City or town Springfield
(If outside city or town limits, write "RURAL")
 (d) Street No. 2804 N. Grant
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 4
 year 1947 hour 1 minute P. M.
 21. I hereby certify that I attended the deceased from 1-11-47, 19____, to 2-4-47, 19____,
 that I last saw her alive on 2/4/47, 19____,
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of both ovaries
 Due to _____
 Due to _____

Other conditions 49A
(Include pregnancy within 3 months of death)

Major findings: thrombosis
 Of operations _____
 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? _____
(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)
 (c) Means of injury 0
 23. Signature [Signature] (M. D. or other)
 Address Springfield Mo Date signed 2/5/47

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.....

Walter E. Hamilton

Licensed Embalmer No.

3888

P. O. Address.....

Providence, R.I.

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.