

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

FILED FEB 28 1947

Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

Registrar's No. 115

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 Springfield Baptist Hospital  
(If not a hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days) 2 days

3. (a) PRINT FULL NAME

Julia Stella De Witt

3. (b) If veteran

name war L

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 Lee De Witt 6. (c) Age of husband or wife if alive 35 years  
7. Birth date of deceased March 16-1912  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
34 10 21 hr. \_\_\_\_\_ min.

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

10. Usual occupation house wife

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

12. Name Green C Peters

13. Birthplace unknown Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Head

15. Birthplace unknown Tenn  
(City, town, or county) (State or foreign country)

16. (a) Informant May Brown

(b) Address Ballings - R-1

17. (a) Burial (b) Date thereof Feb 9-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crane Cemetery

18. (a) Signature of funeral director J. W. Maples

(b) Address Cleaver Mo

19. (a) 2-10-47 (b) W. E. Handley MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stone 104  
(c) City or town rural 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. Ballings - R-1 0  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 7<sup>th</sup>  
year 1947 hour 1 minute 15 A M.

21. I hereby certify that I attended the deceased from 2-5- 1947 to 2-7- 1947  
that I last saw her alive on 2-6- 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death puerperal eclampsia Duration 1 wk

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

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

Other conditions 148 A  
(Include pregnancy within 3 months of death)

Major findings: Of operations 15

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

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

23. Signature C. E. Follen (M. D. or other) \_\_\_\_\_

Address Springfield Mo Date signed 2-7-47

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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.....

*JW. Maples*

Licensed Embalmer No.....

*2985*

P. O. Address.....

*Clear 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.