S. No. 2
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r. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 28 1947

Registration District No.

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8600

Primary Registration District No. 2000

Registrar's No. 253

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: Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Days
(Specify whether)
In this community 15 Years
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. 224 East Thoman
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Augusta Baxter

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex F M 1

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased December (Month) 8, (Day) 1869 (Year)

8. AGE:

Years	Months	Days	If less than one day
77	3	9	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name T T Baker
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Bert Perrigin
(b) Address 300 College

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19,1947 (Month) (Day) (Year)
(c) Place: burial or cremation Clear Creek

18. (a) Signature of funeral director W. L. Dunn
(b) Address Springfield, Mo.

19. (a) 3-19-47 (Date received local registrar) (b) W E Handley M D (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17 th.
year 1947 hour 8 minute 45 A. M.

21. I hereby certify that I attended the deceased from March 8, 1947 to March 17, 1947; that I last saw her alive on March 17, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute cholecystitis with rupture of gall bladder	6 days 36 hours
Due to	
Due to	
Other conditions. Lobar pneumonia (Include pregnancy within 3 months of death)	4 days

Major findings:
Of operations
Of autopsy

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

23. Signature Kenneth C. Coffelt (M. D. or other)
Address Springfield, Mo Date signed 3-18-47

111 (Licensed Embalmer's Statement on Reverse Side)

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 H L McCann

Licensed Embalmer No. 2727.

P. O. Address Springfield Mass.

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.