

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13138

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 364

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:
619 W. Walnut /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 10 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 39
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No. 619 West Walnut 6
(If rural, give location)
No 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Jane Jones
3. (b) If veteran, name war No
3. (c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 19 th. year 1947 hour 1 minute 55 A.M.

4. Sex F M / 5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 1 st. 1858
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 18 1947 to April 18 1947
that I last saw her alive on April 18 1947
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>88</u>	<u>6</u>	<u>18</u>	hr. _____ min.

Immediate cause of death Cerebral Hemorrhage 1299
Duration
Due to Age and fractured hip
2 mo ago
Due to _____

9. Birthplace Near Versailles Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

Other conditions (Include pregnancy within 5 months of death)
Major findings: _____
Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name Charles M. Sims
13. Birthplace ?? Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Louisa Ann Chaney
15. Birthplace ?? ??
(City, town, or county) (State or foreign country)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Underline the cause to which death should be charged statistically.

16. (a) Informant Mamie Ann Jones
(b) Address 619 W. Walnut, Springfield, Mo
17. (a) Burial (b) Date thereof 4-22, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Freedom cemetery,

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) No
(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? _____

18. (a) Signature of funeral director Dunn Funeral Home
(b) Address Springfield, Mo.
19. (a) 4-21-47 (b) W E Handley and
(Date received local registrar) (Registrar's signature)

(Specify type of place)
(c) Means of injury _____
23. Signature Robert Williams (M.D. or other) 0
Address Springfield Mo Date signed 4-21-47

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.....

A. J. McCann

Licensed Embalmer No. *2727*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Man*

Registration District No. *128*

Primary Registration District No. *2000*

Registrar's No. *368*

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 _____ (years, months or days)

3. (a) PRINT FULL NAME *Mary J. Jones*

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 *wid*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased: *Oct* (Month) *1* (Day) *1900* (Year)

8. AGE: Years *88* 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 _____

MOTHER FATHER { 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)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *April* 19 *1947* year *1947* 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 _____

Duration

Due to _____

Due to _____

Other conditions. _____ (Include pregnancy within 3 months of death) *186A*

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) *Accidental* ✓
(b) Date of occurrence *March 1-47* ✓
(c) Where did injury occur? *Springfield Greene miss* ✓
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? *Her home* ✓
While at work? *no* (Specify type of place) *fall* ✓
(e) Means of injury

23. Signature *Gabey Williams* (M. D. or other) ✓
Address *Springfield Mo* Date signed *5-9-47*

SUPPLEMENTARY

13138