

FILED OCT 6 1947  
128

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

Primary Registration District No. 2000

Registrar's No. 814

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:  
609 S. Grant Avenue  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 2 Years  
years, months or days)

3. (a) PRINT FULL NAME Mattie O. Gross

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 Chris Gross

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

7. Birth date of deceased June 14 1869  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>3</u>	<u>0</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business In home

MOTHER FATHER {

12. Name Andrew Radcliffe 9

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Timm

(b) Address Springfield, Mo.

17. (a) Removal (b) Date thereof Sept. 15 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheridan, Wyoming

18. (a) Signature of funeral director J.W. Klingner & Co.

(b) Address Springfield, Missouri

19. (a) 9-15-47 (b) M. E. Handley M.D.  
(Date received local registrar) (Registrar's signature)

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. 609 S. Grant Avenue 6  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 14  
year 1947 hour 11 minute 55 A.M.

21. I hereby certify that I attended the deceased from August 2, 1947, to September 14, 1947;  
that I last saw her alive on September 13, 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Metastatic Carcinoma arising from Carcinoma, Right Breast 3 years  
Due to \_\_\_\_\_ Duration 3 years

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

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

Major findings: 50  
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? \_\_\_\_\_

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

23. Signature Geneth C. Coffey (M. D. or other) M.D.  
Address Springfield, Mo. Date signed 9-15-47

NOV 6 1947

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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 Ogle Stone Jr.

Licensed Embalmer No. 4176

P. O. Address Springfield 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.**