

FILED NOV 22 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36167

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

Primary Registration District No. 2000

Registrar's No. 1005

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: 1115 E. Commercial  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 65 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. S\* 1115 E. Commercial  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Ellen Grant

3. (b) If veteran, name war No  
3. (c) Social Security No. No

4. Sex F / 5. Color or race W  
6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife George Grant  
6. (c) Age of husband or wife if alive ? years

7. Birth date of deceased Oct. 21 1873  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>0</u>	<u>25</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business Housewife

MOTHER FATHER {  
12. Name R. T. Haymes  
13. Birthplace Cleveland Tenn.  
(City, town, or county) (State or foreign country)  
14. Maiden name Catherine Wrinkle  
15. Birthplace Cleveland Tenn.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lenora Hunt  
(b) Address 1115 E. Commercial

17. (a) Burial (b) Date thereof 11-18-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshfield Mo.

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

19. (a) 11-18-48 (b) W. E. Handley, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16  
year 1948 hour 2 minute 50 a.m.

21. I hereby certify that I attended the deceased from October 14, 1948, to NOV 11, 1948;  
that I last saw her alive on NOV 11, 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death Mycocarditis Chronic  
Tuberculosis Pulmonary  
Due to \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy BB

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 D  
Signature G. F. Bechtold M.D. (M. D. or other) M.D.  
Address 630 N. Jefferson Springfield Mo Date signed NOV 17 1948

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 17 1950

VS SEP 28 1959

NOV 24 1949

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.....

*Max Rhodes*

Licensed Embalmer No. ....

4071

P. O. Address.....

*Springfield*

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.

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Shrewsbury

(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 May E Hunt

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 21 1901  
(Month) (Day) (Year)

8. AGE: Years 75 Months \_\_\_\_\_ Days \_\_\_\_\_ (Unless than one day) hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Tenn

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) 11-18-48 (b) W E Handley  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_ Year 1948 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)

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 \_\_\_\_\_

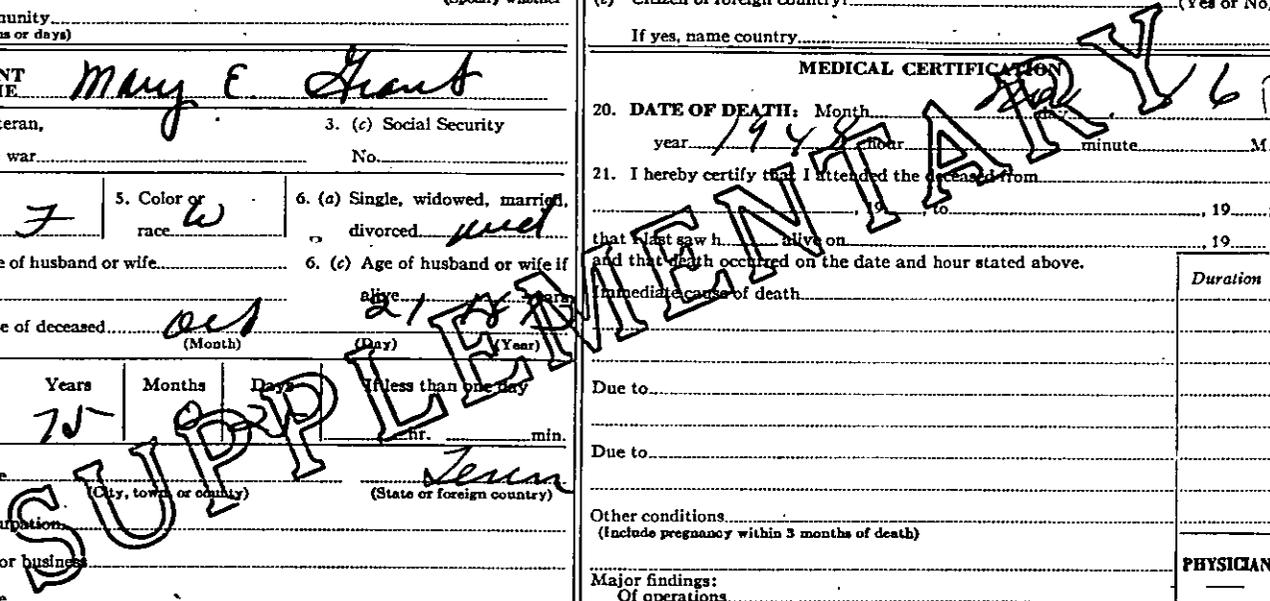
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_



S-36168