

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 22 1957

12793

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 370

|   |                                  |  |  |   |   |  |  |
|---|----------------------------------|--|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Greene</b>  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b> |   |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>  |                                  |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                        | c. CITY OR TOWN <b>Springfield</b> <u>0396</u>  |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Johns Hosp.</b>  |                                  |  | Length of stay in lb <b>50 Yrs.</b>  | d. STREET ADDRESS (If outside, give location) <b>907 E. Madison</b>   |   | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHRISTINA</b> Middle <b>LILLIAN</b> Last <b>HOLLINGSWORTH</b>   |                                  |  |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>14</b> Year <b>1957</b>   |   |  |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH <b>25 April 1894</b>   | 9. AGE (In years last birthday) <b>62</b>                               | IF UNDER 1 YEAR<br>Months _____ Days _____   | IF UNDER 24 HRS.<br>Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>  | 11. BIRTHPLACE (City and state or country) <b>Missouri</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>A. G. Anderson</b>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                                  | 16. SOCIAL SECURITY NO. <b>Unknown</b>   |  | 17. INFORMANT <b>Hospital Records</b> Address _____   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix</b>   |                                  |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____<br>DUE TO (c) _____   |                                  |  |  |   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT <input type="checkbox"/>  | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/>  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>171X</b> |   |   |  |  |
| 20c. TIME OF INJURY<br>Hour _____ Month _____ Day _____<br>a. m. _____ p. m. _____  |                                  |  |  |   |   |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |  | 20f. CITY, TOWN, OR LOCATION  |   | COUNTY STATE   |  |
| 21. I attended the deceased from <b>June 1955</b> to <b>Apr 14, 1957</b> and last saw <sup>her</sup> him alive on <b>Apr 14, 1957</b> . Death occurred at <b>4:48 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |  |  |   |   |  |  |
| 22a. SIGNATURE (Degree or title) <b>James T. Good M.D.</b>  |                                  |  |  | 22b. ADDRESS <b>Springfield, Missouri</b>   |   | 22c. DATE SIGNED <b>4-16-57</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                                  | 23b. DATE <b>4-16-57</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill</b>  |   | 23d. LOCATION (City, town, or county) (State) <b>Jasper County, Mo.</b> |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>Jul Klingner &amp; Co. Spgfd. Mo.</b>   |                                  |  | 25. DATE RECD. BY LOCAL REG. <b>4-16-57</b>  |   | 26. REGISTRAR'S SIGNATURE <b>Edna Williams</b>                          |  |  |

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 ..... Student Embalmer No. .... working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed

*J. B. Klingman*

Licensed Embalmer No. 33

P. O. Address *Spfld*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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