

No. 2  
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7-39  
X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED AUG 30 1948

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Dr. Lemmon Sr. 25937  
State File No. 713  
Registrar's No.

Registration District No. 128 Primary Registration District No. 2000

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: 1523 E. Delmar  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none (Specify whether)  
In this community 24 Years  
years, months or days

3. (a) PRINT FULL NAME Margaret S. Barr  
3. (b) If veteran, name war no 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Dr. B. B. Barr 6. (c) Age of husband or wife if alive dec. years  
7. Birth date of deceased September 16 1864  
(Month) (Day) (Year)

8. AGE: Years 83 Months 11 Days 10 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER  
12. Name Jerome B. Squires  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Synthia McNeeley  
15. Birthplace Warsaw Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Harold Pierce  
(b) Address 1523 E. Delmar

17. (a) Burial (b) Date thereof 8-27-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clinton, Missouri

18. (a) Signature of funeral director H. H. Lohmeyer  
(b) Address Springfield, Missouri

19. (a) 8-27-48 (b) M. J. Handley  
(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") 6  
(d) Street No. 1523 E. Delmar 0  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? no years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 26th  
year 1948 hour 2 minute 45 A.M.

21. I hereby certify that I attended the deceased from Aug. 8, '48, 19\_\_\_\_ to 8/27/48, 19\_\_\_\_;  
that I last saw her alive on 8/26/48, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration 19hda.

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

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

Other conditions Pernicious anemia; senility 10 yrs

Major findings: Of operations 83 13

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) (e) Means of injury \_\_\_\_\_

23. Signature Dr. Lemmon Sr. (M. D. or other) M.D.  
Address Springfield, Mo. Date signed 8/26/48

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

SEP 25 1948

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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

*James B. Laughlin*

Licensed Embalmer No. *4564*

P. O. Address *Springfield, Mo.*

**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.**