

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAR 24 1931

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

W. L. Turner
3/23/31

1. PLACE OF DEATH

County *Greene* Registration District No. *318*
Township _____ Primary Registration District No. *5439*
City *Springfield, Mo.* (No. *Rt. 4*)

File No. _____
Registered No. *101*
St. _____ Ward _____

2. FULL NAME

Demaris Y. Rose
(a) Residence, No. *Rt. 4* St. _____ Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Widowed</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>James F. (Dec)</i>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>May 29 - 1850</i>				
7. AGE	YEARS <i>80</i>	MONTHS <i>8</i>	DAYS <i>5</i>	IF LESS than 1 day,hrs. ormin.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Handwork</i>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Prayser Co. - Ind.</i>				
MOTHER	13. NAME <i>Joseph Greenleaf</i>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ind.</i>			
	15. MAIDEN NAME <i>Sarah State</i>			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ind.</i>				
17. INFORMANT <i>Mollie Meighen</i> (ADDRESS) <i>Rt. 7 - Springfield, Mo.</i>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Illinois</i> DATE <i>3-1-31</i>				
19. UNDERTAKER <i>Ill. ma. Lohmeyer Funeral Home</i> (ADDRESS) <i>534 St. Louis</i>				
20. FILED <i>2</i> <i>5</i> 19 <i>31</i> <i>Ross Sharp</i> Registrar.				

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb. 4 - 1931*

22. I HEREBY CERTIFY, That I attended deceased from *19* 19*29*, to *Jan 1* 19*31*
I last saw her alive on *Jan. 1* 19*31* Death is said to have occurred on the date stated above, at *5:27 A.M.*
The principal cause of death and related causes of importance were as follows:
Date of onset

Concave of Left Ovary + uterus (probably) carcinomatous, 4 3/4
4 9/16
Other contributory causes of importance: *History of cyst of ovary*

Name of operation _____ Date of _____
What test confirmed diagnosis? *X Ray* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *No*
so, specify _____
(Signed) *W. L. Turner*, M. D.
(Address) *318 1/2 Central Springfield, Mo.*

