

NOV 17 1938

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

35716

Do not use this space.

1. PLACE OF DEATH

(a) County Greene
(b) Township Springfield
(c) City Springfield

Registration District No. 316

Primary Registration District No. 2001

Registered No. 786

(e) Length of residence in city or town where death occurred yrs. mos. ds. 5 1 2

(d) Street No. Burgess Hospital (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(f) How long in U. S., if of foreign birth? yrs. mos. ds. _____

2. PRINT FULL NAME

(a) Residence, No. 1538 Washington St. (Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Jesse B. Thompson (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 14 - 1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
41 2 10

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Wife
9. Industry or business in which work was done, as saw mill, bank, etc. In home
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) Jenn. Mo.

FATHER 13. NAME Andrew R. Moor

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jenn. Mo.

MOTHER 15. MAIDEN NAME Diatha Denton

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jenn. Mo.

17. INFORMANT (ADDRESS) Jesse B. Thompson Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL East Lawn DATE Oct 26 38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. Hines & Co. Springfield, Mo.

20. FILED Oct 26 1938 Chas. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 24 1938

22. I HEREBY CERTIFY, That I attended deceased from Oct. 1 - 1938, to Oct. 24 1938
I last saw her alive on Oct. 24 1938 Death is said to have occurred on the date stated above, at 1:10 P.M.
The principal cause of death and related causes of importance were as follows:

Date of onset 10/24/38
Cardiac Embolism

Other contributory causes of importance: Hysterectomy

Name of operation Hysterectomy Date of 10/10/38
What test confirmed diagnosis? clinical 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
If so, specify _____
(Signed) Arthur S. Hines M. D.
(Address) 450 1/2 E. Cecil St.

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.

1213

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,

Roy A. Gav

1763: Karen D. Hoblett # 4005

or by Mrs. Max Rhodes

Registered Apprentice No. 117, working under my personal supervision.

Signed J.B. Klugner

Licensed Embalmer No. 3358

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

35-716
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. _____
 (b) Township _____ Primary Registration District No. _____ Registered No. _____
 (c) City Springfield (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
 (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
41 2 10

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19__

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19__ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 24 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19__, to _____, 19__.

I last saw h. _____ alive on _____, 19__. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Cerebral Embolism Date of onset _____

54 B°

Other contributory causes of importance:

Hysterectomy
Fibroid uterus

Name of operation Hysterectomy Date of Oct. 11, 1938

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? no Date of injury _____, 19__

Where did injury occur? no (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

If so, specify _____

(Signed) Arthur D. Knabb M. D.

(Address) Springfield 1938

(Knabb)

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED BY PHYSICIAN. ROWENA WOODRUFF LAW.

SUPPLEMENTARY

PROVIDED THAT YOU HAVE BEEN ESTABLISHED FOR THE PURPOSES OF THE ACT AND THAT YOU ARE A U.S. CITIZEN.