

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.

REC'D MAR 13 1939

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

6555  
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 318  
(b) Township Springfield Primary Registration District No. 2004 Hosp Registered No. 154  
(c) City Springfield (d) Street No. Burge Hosp 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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

BLANCHE WILKERSON  
(a) Residence, No. 2000 Benton 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Claude J. Wilkerson  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 13, 1893  
7. AGE YEARS 45 MONTHS 2 DAYS 5 If LESS than 1 day, ..... hrs. or ..... min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
9. Industry or business in which work was done, as saw mill, bank, etc. 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) Mo. 0

FATHER 13. NAME Wm. Rose 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 9

MOTHER 15. MAIDEN NAME Carrie Prosser

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

17. INFORMANT (NAME) (ADDRESS) Claude J. Wilkerson

18. BURIAL, CREMATION OR REMOVAL East Lawn DATE Feb. 19, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. Higgins & Co.

20. FILED 2-19-39 Chas. W. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) February 18, 1939

22. I HEREBY CERTIFY, That I attended deceased from January 16, 1939, to February 18, 1939  
I last saw her alive on February 18, 1939 Death is said to have occurred on the date stated above, at 7:45 a.m.  
The principal cause of death and related causes of importance were as follows:

Uterine Cancer

Date of onset

Other contributory causes of importance:

Name of operation Lap. & clinical Date of operation .....  
What test confirmed diagnosis Lap. & clinical Was there an autopsy? Yes

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? .....  
If so, specify .....  
(Signed) Henry J. Krash M. D.

(Address) Springfield, Missouri

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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 *J. B. Klingner*  
Licensed Embalmer No. *3358*  
P. O. Address.....

**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.**