

REC'D APR 13 1939

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

Dr. Fred White

10825
Do not use this space.

1. PLACE OF DEATH
(a) County GREENE Registration District No. 316
(b) Township 3 Primary Registration District No. 2001 Registered No. 238
(c) City SPRINGFIELD (d) Street No. 903 W. Florida 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 Sarah Delphine Nurse
(a) Residence, No. 1508 W. Beaver Phelps (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 (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED (MARRIAGE OR) WIFE OF Geo. P Nurse (dec 1938)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 6, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 6 13

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. In Home

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 19, 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-5, 1939, to 3-19, 1939
I last saw her alive on 3-19, 1939 Death is said to have occurred on the date stated above, at 12:30 A m.

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

Senility Date of onset

Other contributory causes of importance:
Encephalomalacia
Arteriosclerosis

Name of operation none Date of clinical
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? _____
If so, specify _____
(Signed) Fred White, M. D.
Local Registrar George D. George (Address) Springfield

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.

FATHER 13. NAME (Max) Warner
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.

MOTHER 15. MAIDEN NAME Nancy Johnson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.

17. INFORMANT E. E. Nurse
(ADDRESS) 1508 W Phelps, City.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Greenlaw DATE Mar 21, 1939

19. FUNERAL DIRECTOR (NAME) Alvin Johnson
(ADDRESS) Springfield, Mo.

20. FILED Mar 21, 1939 Local Registrar George D. George

WRITE PLAINLY WITH DARK INK

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.

SEP 10 1958

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.....

Licensed Embalmer No.....

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.