

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.

1939 AUG 24 1939

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

25601
Do not use this space.

1. PLACE OF DEATH **GREENE**

(a) County **GREENE** Registration District No. **318**
 (b) Township **SPRINGFIELD** Primary Registration District No. **2001** Registered No. **538**
 (c) City **SPRINGFIELD** (d) Street No. **Springfield Hospital** 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 **21** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **DeLoria Maxine Armantrout Morris R # 10**

(a) Residence, No. **Route No. 10** St. (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) **Married**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **April 8, 1913**

7. AGE YEARS **26** MONTHS **7** DAYS **25** If LESS than 1 day, hrs. or min.

OCCUPATION 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.
 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) **Clayton New Mexico**

FATHER 13. NAME **Lawrence Armantrout**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Phrymouth Indiana**

MOTHER 15. MAIDEN NAME **Della Tupper**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Sacred, Mo.**

17. INFORMANT (ADDRESS) **John Morris R # 10**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Greenlawn** DATE **July 5, 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Thompson Springfield, Mo**

20. FILED **July 5, 1939** **Chas A Berger** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **7 - 3 - 19 39**

22. I HEREBY CERTIFY, That I attended deceased from **5 - 1**, 19**39** to **7 - 3**, 19**39**.
 I last saw her alive on **7 - 3**, 19**39**. Death is said to have occurred on the date stated above, at **7:45** p.m.
 The principal cause of death and related causes of importance were as follows:
Miliary Tuberculosis 6-1-39
320
 Other contributory causes of importance:
Menstrual Toxemia 6-28-39
Menstrual Toxemia
 Name of operation **none** 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**
 If so, specify.....
 (Signed) **W. T. Walsh**, M. D.
 (Address) **Springfield, Mo**

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.....

Ralph Thieme

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Ralph Thieme

Licensed Embalmer No. *3684*

P. O. Address.....

Springfield,

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.

X