

1939 AUG 14 1939

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

25631
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 318
(b) Township SPRINGFIELD Primary Registration District No. 2001
(c) City SPRINGFIELD (d) Street No. 2000 Block Springfield, Mo. Registered No. 569
(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. 5110 W Eighth Tulsa Okla Tulsa Okla
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William Howard Testerman
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 16 1914
7. AGE YEARS MONTHS DAYS IF LESS THAN 1 day, hrs. or min. 22 10 29
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
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) Annaworth Nebraska

13. NAME James Harvey Hughes

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

15. MAIDEN NAME Grace Charlet Mays

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

17. INFORMANT (ADDRESS) Mrs. Grace Mays
Tulsa Okla

18. BURIAL, CREMATION, OR REMOVAL PLACE Eastlawn DATE July 18 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Fred A. Thome
Springfield Mo

20. FILED July 17 1939 Chas A. George
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 15 1939
22. I HEREBY CERTIFY That I attended deceased from July 13 1939 to July 15 1939
Last seen alive on July 15 1939. Death is said to have occurred on the date stated above, at 10:00 m.

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

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis History 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
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) Howard H. Salzer, M. D.
Cassville Mo. (Address)

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.

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State of Rhode Island

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

R. Thierme

Registered Apprentice No.

working under my personal supervision.

Signed

R. Thierme

Licensed Embalmer No.

3681

P. O. Address

Sy. Me...

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

25-631
Do not use this space.

1. PLACE OF DEATH
 (a) County Greene Registration District No. 318
 (b) Township _____ Primary Registration District No. 2001 Registered No. 569
 (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 Madeline Testerman
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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.
	<u>32</u>	<u>10</u>	<u>19</u>	

OCCUPATION
 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) _____

FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 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 Sept 1 1939 Chas A George reg
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-15-1939

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:
Encephalitis
not epidemic in form
 Other contributory causes of importance: 780

Name of operation _____ Date of _____
 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? _____ 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) Glenn W. Salzer, M. D.
 (Address) Assville Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

1939

S-25613