

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.

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

36058

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. 1411 N. Johnston 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.

Registered No. 7442. PRINT FULL NAME Mrs. Agnes Wilkins

(a) Residence, No. 1411 N. Johnston 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>B. W. Wilkins</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>March 23, 1878</u>		
7. AGE YEARS <input checked="" type="checkbox"/> <u>61</u>	MONTHS <u>6</u>	DAYS <u>14</u>
If LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>	
	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) <u>Greene Co Mo</u>		
FATHER	13. NAME <u>Wm</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>	
MOTHER	15. MAIDEN NAME <u>Wm</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>	
17. INFORMANT <u>B. W. Wilkins</u> (ADDRESS) <u>Springfield, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Eastlawn</u> DATE <u>Oct. 9</u> 19 <u>39</u>		

19. FUNERAL DIRECTOR (NAME) H. H. Lohmeyer
(ADDRESS) Springfield, Mo.

20. FILED Oct 9 1939 Chas A. George, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from 10/5 1939 to 10/6 1939

I last saw her alive on 10/8 1939. Death is said to have occurred on the date stated above, at 10 p.m.

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

Thrombosis of Left Popliteal Vein Date of onset 10/5/39

Other contributory causes of importance

Artery's Sclerosis
Fall from porch

Name of operation None Date of
What test confirmed diagnosis? Physic Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide accident Date of injury 9/30 1939

Where did injury occur? Home
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None
Nature of injury Fall from porch
Abdominal trauma

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify.....
(Signed) Chas A. George, 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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed Walter E. Hamiller

Licensed Embalmer No. 3808

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.

X