

Registration District No. 31330

Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Greene 2
(b) City or town Springfield
(c) Name of hospital or institution: 434 E. Cherry St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 115
(Specify whether years, months or days)

In this community 115 years, months or days

3. (a) PRINT FULL NAME MAUDE JOSEPHINE ALLONAS

3. (b) If veteran, name war. ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive 18 years

7. Birth date of deceased July 25 1860
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 6 If less than one day hr. min.

9. Birthplace Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Nurse

11. Industry or business Nursing

12. Name Wm. E. McMillion

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Josephine

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Otto Varley

(b) Address Springfield, Mo.

17. (a) Date of death Nov 5 1939
(b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Old Swedish Cemetery

18. (a) Signature of funeral director W. W. [Signature]

(b) Address Springfield, Mo.

19. (a) Nov. 5 1939 (Date received local Registrar) (b) Thomas A. George (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 434 E. Cherry St
(If rural, give location)
(e) If foreign born, how long in U. S. A. 115 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 1st
year 1939 hour 5 minute 30 A. M.

21. I hereby certify that I attended the deceased from Nov 2, 1939, to Nov 2, 1939;
that I last saw her dead on Nov 2, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to 14 hr

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 11

23. Signature W. W. White (M. D. or other) 11-2
Address Cowles Greene County Date signed 11/2/39

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.

X

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed

Licensed Embalmer No. *4071*

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.