

Registration District No. 318Primary Registration District No. 2001

812

## 1. PLACE OF DEATH:

- (a) County Greene 1  
 (b) City or town Springfield  
 (c) Name of hospital or institution: Burg's Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 days  
 (Specify whether

In this community  
years, months or days3. (a) PRINT FULL NAME FANNIE WALLIS3. (b) If veteran, name war  3. (c) Social Security No. 4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Widow6. (b) Name of husband or wife Luther Wallis 6. (c) Age of husband or wife if alive 19 years7. Birth date of deceased Nov 19 1858  
(Month) (Day) (Year)8. AGE: Years 80 Months 11 Days 18 If less than one day no.  
hr. min.9. Birthplace (City, town, or county) no. (State or foreign country)10. Usual occupation House work11. Industry or business In home12. Name Hall13. Birthplace unknown14. Maiden name Mrs. Freeman15. Birthplace unknown16. (a) Informant's own signature Lee Wallis(b) Address Springfield, Mo.17. (a) Burial (b) Date thereof Nov. 8-1939

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Not Comfort Cem.18. (a) Signature of funeral director J. W. Guignard(b) Address Springfield, Mo.19. (a) Nov 7, 1939 (b) Chas. A. George

(Date received local registrar) (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. R # 11  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.?

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 7 Nov. 1939  
year 1939 hour 730 minute A. M.21. I hereby certify that I attended the deceased from 10/20/39  
1939, to Nov 11, 1939.  
that I last saw her alive on 11/6, 1939.  
and that death occurred on the date and hour stated above.

Immediate cause of death

Paralysis of muscles of throat  
Due to Hypertension & toxicity from general senility  
Due to general senilityOther conditions (Include pregnancy within 3 months of death) noMajor findings: Of operations noOf autopsy no

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

- (a) Accident, suicide, or homicide (specify) no  
 (b) Date of occurrence no  
 (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? no

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

23. Signature J. W. Guignard (M. D. or other) 11/7/39  
Address Springfield Date signed 11/7/39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

822

**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

*William Paul Howard*

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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

39594

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. \_\_\_\_\_ 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.

Registered No. 812

2. PRINT FULL NAME

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

Fannie Wallis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid  
 (write the word)

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.  
80 11 18

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 MOTHER

13. NAME \_\_\_\_\_  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_  
 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 1-15-40 Chas A George MD Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-7-1939

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:

Senile  
Paralysis of muscles of throat  
Hyperextension & Injury  
General Senility

Date of onset \_\_\_\_\_

Other contributory causes of importance: g.j.k

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) S. J. Freeman, M. D.

(Address) Springfield Mo

SUPPLEMENT

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.

