

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

2355  
Do not use this space.

FILED FEB 13 1940

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.

1. PLACE OF DEATH

(a) County..... GREENE Registration District No..... 316

(b) Township..... Primary Registration District No..... 2001 Registered No..... 18

(c) City..... SPRINGFIELD (d) Street No..... 1301 N. Glenstone 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 407 Mrs. Eliza E. Teel

(a) Residence, No. Kingston, Oklahoma 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 24, 1859

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>80</u>	<u>6</u>	<u>11</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) Georgia

FATHER

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Robert Love Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Kingston, Okla. DATE Jan. 6, 1940

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

20. FILED 1/6 1940 Chas. K. George, M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 5, 1940

22. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1897 to Jan 5, 1940

I last saw her alive on Jan 5, 1940 Death is said to have occurred on the date stated above, at 11 a.m.

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

Chronic Tubercular Heart Disease

Date of onset Several years

Other contributory causes of importance: A2W

Name of operation None Date of

What test confirmed diagnosis? None Was there an autopsy? None

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? No 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 no

Nature of injury no

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

If so, specify (Signed) Robert Williams, 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 *L. Doolin Gorman*

Licensed Embalmer No. *3177*

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.**