

FILED FEB 13 1940

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

Dr. W. H. ...  
2358  
Do not use this space.

1. PLACE OF DEATH **GREENE** Registration District No. **316**  
 (a) County  
 (b) Township  
 or  
 (c) City **SPRINGFIELD** Primary Registration District No. **2008** Registered No. **21**  
 (d) Street No. **625 S. Fort.** (If death occurred in Hospital or Institution, write its name instead of street and number) St.   
 (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 **Artrmitia E. Pike**  
 (a) Residence, No. **625 S. Fort.** 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 (write the word) **Widowed**  
 5A. IF MARRIED, WIDOWED, OR DIVORCED (HUSBAND OF OR) WIFE OF **William F. Pike**  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 20, 1851**  
 7. AGE YEARS **88** MONTHS **5** DAYS **17** If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **House wife**  
 9. Industry or business in which work was done, as saw mill, bank, etc. **at home**  
 10. Date deceased last worked at this occupation (month and year) **1939** 11. Total time (years) spent in this occupation **17**  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Blount County, Ind.**  
 FATHER 13. NAME **Dr. G. W. Roberts**  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Tennessee**  
 MOTHER 15. MAIDEN NAME **Jennie Loy**  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Tennessee**  
 17. INFORMANT (ADDRESS) **Mrs. Rose Jersey, Springfield, Mo.**  
 18. BURIAL, CREMATION, OR REMOVAL PLACE **Wayland** DATE **1-9-40**  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Alma Schreyer, Springfield, Mo.**  
 20. FILED **119** 19**40** **Chas. K. Dergs** Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1-7, 1940**  
 22. I HEREBY CERTIFY, That I attended deceased from **Nov 15, 1939, to Jan 7, 1940**  
 I last saw him alive on **Jan 7, 1940**. Death is said to have occurred on the date stated above, at **8:15 P.M.**  
 The principal cause of death and related causes of importance were as follows:  
**Lobar Pneumonia** Date of onset **Jan 1, 1940**  
 Other contributory causes of importance: **Fracture of right hip** Date **Dec 20, 1939**  
**Senility**  
 Name of operation **None** 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? **Accident** Date of injury **12-20, 1939**  
 Where did injury occur? **at home** (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury **fell in house at home**  
 Nature of injury **fractured hip**

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify (Signed) **J. Newton Waller**, 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.....

*Chas C George*

....., Registered Apprentice No. *204*

working under my personal supervision.

Signed.....

*Lewis G. Schaff*

Licensed Embalmer No. *3802*

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.**

*Y*