

No. 2
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17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14908

State File No.

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 369

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 847 Summit Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days 1-5-5

3. (a) PRINT FULL NAME Fannie Bird

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race Colored

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased March 6 1863
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>1</u>	<u>10</u>	hr. min.

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

10. Usual occupation Laundress

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Missie Trout

(b) Address 2011 Washington

17. (a) Burial (b) Date thereof 4-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Mem

18. (a) Signature of funeral director H. O. Campbell

(b) Address 867 Washington

19. (a) 4-16-40 (b) W. E. Handley, M.D.
(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 limit, write "RURAL")

(d) Street No. 847 Summit Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th.
year 1940 hour 3:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from March 12, 1940 to April 16, 1940
that I last saw h^{er} alive on " 12, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Tumor, Uterine, probably Malignant - primary

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____

Of operations _____

Of autopsy _____

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)

23. Signature J. Murch (M. D. or other) _____
Address Springfield, Mo. Date signed 4, 16, 40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

W. P. Campbell

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

W. P. Campbell

Licensed Embalmer No.

1747

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.

X