

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **18404**  
Registrar's No. **422**

Registration District No. **316**  
Primary Registration District No. **2001**

1. PLACE OF DEATH:

(a) County **GREENE**  
(b) City or town **Springfield**  
(c) Name of hospital or institution:  
**1910 Grace St**  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**  
(c) City or town **Springfield,**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1910 Grace, Springfield, Mo.**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **7th.**  
year **1940** hour **4** minute **P.** M.

21. I hereby certify that I attended the deceased from  
**July**, 19**36**, to **May 7**, 19**40**;  
that I last saw him alive on **May 7**, 19**40**,  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**Acute Rheumatic Carditis**

Due to **Acute Rheumatic Fever**

Due to **5/6/40**

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations **Obesity (Glandular)**  
Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?  
**984**  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature **W. E. Haudley** (M. D. or other) \_\_\_\_\_  
Address **Springfield Mo** Date signed **5/8/40**

3. (a) PRINT FULL NAME **Florence E. Able** **140**

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

4. Sex **F.** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Jas. A** 6. (c) Age of husband or wife if alive **37** years

7. Birth date of deceased **Oct 27 1907**  
(Month) (Day) (Year)

8. AGE: Years **32** Months **6** Days **10** If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Jefferson Barracks, Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

12. Name **Casper Gerhardt**

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

14. Maiden name **Irene Salls**

15. Birthplace **St. Louis, County Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Jas. A. Able**

(b) Address **1910 Grace, Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **5-9-1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn, City.**

18. (a) Signature of funeral director **Dunn Funeral Home**

(b) Address **629 W. Walnut, Springfield, Mo.**

19. (a) **5-9-40** (b) **W. E. Haudley**  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

**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.....

*Hoyd W. Fox*

Licensed Embalmer No. *2910*

P. O. Address *679 W Walnut*

**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