

No. 2
1-10-39
-17-39
1 X27

MAILED AUG 9 1940
Registration District No. 316

Primary Registration District No. 2001

Registrar's No. 554

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6
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days in
(Specify whether In this community Springfield Baptist Hospital
years, months or days)

3. (a) PRINT FULL NAME Phyllis Marie Utley 340
3. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 18, 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 2 13 hr. min.

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER { 12. Name Mr. Ivan Utley
18. Birthplace Bolivar Mo.
(City, town, or county) (State or foreign country)

{ 14. Maiden name Edna Hensler
15. Birthplace Bolivar Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ardis J. Hensler
(b) Address Bolivar, Mo.

17. (a) Burial (b) Date thereof July 2, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Boyle Cemetery

18. (a) Signature of funeral director W. E. Hensler
(b) Address Bolivar, Mo.

19. (a) July 1, 1940 (b) W. E. Hensler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Pack
(c) City or town Bolivar
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1
year 1940 hour 6 minute 15 A.M.

21. I hereby certify that I attended the deceased from June 1st
1940 to July 1st 1940
that I last saw her alive on June 30 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal toxemia

Due to Strep throat

Due to _____

Other conditions 1150
(Include pregnancy within 3 months of death)

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? _____

Signature W. H. Burd (Specify type of place)
Where at work? _____ (M. D. or other)

Address 410 Woodruff Bldg Date signed 7-1-40

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.....

Licensed Embalmer No.....

P. O. Address.....

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