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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED SEP 16 1940

State File No. 28533

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 688-A

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: 525 E. Madison 9 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community 424

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. 525 E. Madison (If rural, give location)

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

3. (a) PRINT FULL NAME Sara E. Dalgliesh

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife John Dalgliesh

6. (c) Age of husband or wife if alive Dec years

7. Birth date of deceased August 7, 1855 (Month) (Day) (Year)

8. AGE: Years 85 Months 0 Days 14 If less than one day ____ hr. ____ min.

9. Birthplace New York City N.Y. (City, town, or county) (State or foreign country)

10. Usual occupation On Home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. F. P. Estes

(b) Address Springfield, Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-22-40 (Month) (Day) (Year)

(c) Place: burial or cremation New Haven Conn

18. (a) Signature of funeral director Alma Lohmeyer

(b) Address Springfield Mo

19. (a) Aug 22, 1940 (Date received local registrar) W. E. Handley M.D. (Registrar's signature) RJB

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 21st year 1940. hour 1 PM minute ____ M.

21. I hereby certify that I attended the deceased from Jan. 1940, 1940, to Aug, 1940. that I last saw her alive on Aug. 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Bronchial Pneumonia — Duration 2 Days.

Due to Chr. Bronchitis Asthma

Due to ____

Other conditions — (Include pregnancy within 3 months of death) 10 PM

Major findings: Of operations none —

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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature Ronald T. Elkins (M. D. or other) 1

Address Springfield Mo. Date signed 8-23-40.

(Licensed Embalmer's Statement on Reverse Side)

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. 3444

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.