

No. 2  
5-17-39  
P-1 X23159

Registration District No. 10-000 318

Primary Registration District No. 2001

Registrar's No. 953

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(c) Name of hospital or institution: Springfield Baptist Hospital  
(1) In hospital or institution, write street number or location  
(d) Length of stay: In hospital or institution 4 hours  
(Specify whether years, months or days) 20 years 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Springfield Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Route #11 Box 248 B.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME BESSIE Bradford EMBREY

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 Married  
6. (b) Name of husband or wife L. Glenn Embrey 6. (c) Age of husband or wife if alive 43 years  
7. Birth date of deceased December 10 1894  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>45</u>	<u>11</u>	<u>16</u>	hr. _____ min. _____

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

10. Usual occupation None - Housewife

11. Industry or business None

12. Name James A. Bradford

13. Birthplace Bellevue Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Root

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

16. (a) Informant L. Glenn Embrey

(b) Address Springfield Mo. Route # 11

17. (a) Burial (b) Date thereof Nov. 28, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director H. C. Higgins

(b) Address Springfield, Mo.

19. (a) 11-28-40 (b) W. E. Handley MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 26<sup>th</sup>  
year 1940 hour 10:55 minute A. M.

21. I hereby certify that I attended the deceased from 11/20/1940  
~~11/20/1940~~ to 11/26, 1940,  
that I last saw her alive on 11/26, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia - Pharynx  
Chronic

Due to Chronic asthma

Due to F. B. Latent

Other conditions acute fever  
(Include pregnancy within 3 months of death)  
from influenza attack

Major findings:  
Of operations None

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) None

(b) Date of occurrence None

(c) Where did injury occur? None  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
None

(e) While at work? (Specify type of place) (e) Means of injury

23. Signature D. F. Zaecy (M. D. or other)  
Address Springfield Mo Date signed 11/26/40

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

MOTHER FATHER

11 B

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**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 Self

....., Registered Apprentice No. ....

working under my personal supervision.

Signed R. H. Meine

Licensed Embalmer No. 3681

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, fact should be so stated above.**

X

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38744  
Registrar's No. 953

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 318

Primary Registration District No. 2001

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

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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

3. (a) PRINT FULL NAME Bessie Bradford Embury

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced u

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 45 Months 11 Days 16 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant (b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 2-10-41 (Date received local registrar) (b) W. E. Handley (Registrar's signature)

20. DATE OF DEATH Month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Spontaneous  
myocardial infarction  
Thorax

Due to Chro. asthma

Due to T.B. Latent of lungs

Other conditions acute Feav.  
(Include pregnancy within 3 months of death)  
Flu influenza attack

Major findings: Of operations \_\_\_\_\_

Of autopsy 27

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? \_\_\_\_\_

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

23. Signature S. J. Freeman (M. D. or other) M.D.  
Address Springfield, Mo. State signed \_\_\_\_\_

SUPPLEMENTARY

