S. No. 2
—11-10-39
v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED JAN 10 1941

Dr. Feller.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42536

Registration District No. 318 Primary Registration District No. 2001 Registrar's No. 1010

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:
2204 N. National
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Several Years
years, months or days) 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield Mo.
(If outside city or town limits write "RURAL")

(d) Street No. 2204 N. National
(If rural, give location)

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

3. (a) PRINT FULL NAME Rachel N. Follis

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex F.M.

5. Color or race White

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

6. (b) Name of husband or wife Joseph Follis

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

7. Birth date of deceased Sept. (Month) 25 (Day) 1856 (Year)

8. AGE: Years 84 Months 2 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business

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

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

16. (a) Informant Mrs. Fred Armstrong
(b) Address 2204 N. National

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 19, 1940 (Month) (Day) (Year)
Burial
(c) Place: burial or cremation Litchfield, Ill.

18. (a) Signature of funeral director Dunn Funeral Home
(b) Address Springfield, Mo.

19. (a) Dec. 19, 1940 (Date received local registrar) (b) W. E. Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18
year 1940 hour 7:45 minute P. M.

21. I hereby certify that I attended the deceased from 8-30-40
[illegible], 19[illegible], to Dec. 18, 1940
that I last saw her alive on 12-17, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchial Pneumonia	12-14-40
Due to	
Due to	
Other conditions: Chronic Coronary Sclerosis (Include pregnancy within 3 months of death)	
Senility	
Major findings: Of operations	
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 C. E. Feller (M. D. or other)
Address Springfield Mo. Date signed 12/17/40

(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 Floyd W. Fox

Licensed Embalmer No. 2910

P. O. Address 629 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.