

No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

APR 13 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14540

State File No. _____

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 310

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

1. PLACE OF DEATH: **GREENE**
 (a) County _____
 (b) City or town Springfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Burge Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 days
 (Specify whether _____)
 In this community 4 days
 years, months or days)

3. (a) PRINT FULL NAME MARIE Olivia HALE
 3. (b) If veteran, name war No
 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 George S Hale
 6. (c) Age of husband or wife if alive 64 years
 7. Birth date of deceased July 18 1872
 (Month) (Day) (Year)

8. AGE: Years 1-68 Months 8 Days 23
 If less than one day _____ hr. _____ min.

9. Birthplace Vail - (Crawford Co) Iowa
 (City, town, & county) (State or foreign country)

10. Usual occupation house wife

11. Industry or business _____

MOTHER FATHER { 12. Name FRED. kindquist
 13. Birthplace Unknown Sweden
 (City, town, or county) (State or foreign country)
 14. Maiden name MARIE OLSON
 15. Birthplace Unknown Sweden
 (City, town, or county) (State or foreign country)

16. (a) Informant Charles kindquist
 (b) Address Seymour, Mo Rte 4

17. (a) removal (b) Date thereof APRIL 11, 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Douglas Co, Mo

18. (a) Signature of funeral director Clinton beard

(b) Address Ava Mo

19. (a) 4-11-41 (b) W. E. Standley MD
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Douglas
 (c) City or town Dogwood
 (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 April day 11th
 year 1941 hour 8:30 minute 30 P.M.

21. I hereby certify that I attended the deceased from Mar 16, 1941 to April 11, 1941
 that I last saw her alive on Apr 11, 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Postoperative shock 2 days
 Due to operation for carcinoma of uterus 2 yrs
 Due to _____
 Other conditions primary
 (Include pregnancy within 3 months of death)

Duration
 2 days
 2 yrs
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

Major findings: Ca of fundus extending into cervix
 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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 Signature J. R. Farthing MD (M. D. or other) MD
 Address Springfield, Mo Date signed 4-13-41

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, fact should be so stated above.

X