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5-17-39  
X28390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
ED SEP 14 1942 138

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Dr. Burke 27210  
State File No. \_\_\_\_\_

Registration District No. 316

Primary Registration District No. 2000

Registrar's No. 639A

39  
2  
6

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

**1. PLACE OF DEATH:**

(a) County GREENE

(b) City or town Springfield City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Burge Hospo  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Greene 39

(c) City or town Springfield 2  
(If outside city or town limits, write "RURAL") 6

(d) Street No. 305 S. Grant  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

**3. (a) PRINT FULL NAME** Maude Yoakum

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Earnest Yoakum 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased AUG 24 - 1887  
(Month) (Day) (Year)

**8. AGE:** Years 55 Months 0 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Herman A. Higgins

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

14. Maiden name Sarah I. Schuefer

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

16. (a) Informant Earnest Yoakum

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Sept. 1, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director H. H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 9-3-42 (b) Dr. W. J. H. [Signature]  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month August day 29  
year 1942 hour 12 minute 25 a. m.

21. I hereby certify that I attended the deceased from Aug 28 to Aug 29 1942  
that I last saw her alive on Aug 28 and the death occurred on the date and hour stated above.

Immediate cause of death Pneumo-pneumonia Duration 3 days

Due to Apoplexy 1 wk

Due to Hypertension Years

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 107  
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? \_\_\_\_\_

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

23. Signature W. J. H. [Signature] (M. D. or other) W. J. H.  
Address 410 Woodruff Bldg Date signed 9/31/42

984 (Licensed Embalmer's Statement on Reverse Side) Springfield, Mo.

SEP 1 1942

**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 Walter E. Hamilton  
Licensed Embalmer No. 3808  
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.**