

No. 2
13-40
17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. Glenn

FILED AUG 23 1943

State File No. 28307

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 624

67-9
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: Bapst. Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Weeks
(Specify whether years, months or days)

In this community 68 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Rural Taylor Township
(If outside city or town limits, write "RURAL")

(d) Street No. Springfield Route # 2
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME Jimmie Patterson Wells

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 3
year 1943 hour 12 minute 50 p. M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife James F. Wells

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

7. Birth date of deceased Nov. 29 1874
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 13 1943 to Aug 3 1943
that I last saw her alive on Aug 3 1943
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>68</u>	<u>8</u>	<u>4</u>	hr. min.

Immediate cause of death Cerebral hemorrhage
Due to _____

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

10. Usual occupation Housewife

11. Industry or business _____

Due to Hypertensive brain arteriosclerosis
Other conditions (Include pregnancy within 3 months of death)
Major findings: 830

MOTHER FATHER

12. Name Jimmie Patterson

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

14. Maiden name Valmora

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

Of antopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant James F. Wells

(b) Address Route # 2 Springfield, Mo.

17. (a) Burial (b) Date thereof Aug. 5, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

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? _____

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

(b) Address Springfield, Mo.

19. (a) 8-5-43 (b) H. W. Handley
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(b) Means of injury _____

23. Signature Robert Glenn (M. D. or other) _____
Address Springfield, Mo. Date signed 8-5-43

984

OCT 27 1943

NOV 1 1944

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. Hamelton

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.

X