V. S. No. 2
100M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 25 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26633

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 7194

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Frisco Hospital O (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7-31-44 to 8-17-44 (Specify whether

In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

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

(d) Street No. 457 E. Elm Street (If rural, give location) NR

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Pearl C Townes

3. (b) If veteran, name war None

3. (c) Social Security No. Unknown

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife George Townes

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

7. Birth date of deceased June (Month) 9 (Day) 1876 (Year)

8. AGE:

Years	Months	Days	If less than one day
68	2	7	hr. min.

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

10. Usual occupation Clerk

11. Industry or business R R.

FATHER
12. Name Thos. Comstack
13. Birthplace New York (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Margaret Watson
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Dr. T. E. Collins

(b) Address 122 N. 7th St.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-17-44 (Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) 8-17-44 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month aug. day 16 year 1944 hour 11:45 PM minute ..... M.

21. I hereby certify that I attended the deceased from Carcinoma of Colon 7-31, 1944 to 8-16, 1944; that I last saw her alive on 8-16-44, 19..; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Colon.

Due to Metastasis to liver and other organs

Due to

Other conditions — (Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

Duration

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 A. C. Mallen (M. D. or other)

Address [illegible] Date signed 8-17-44

(Licensed Embalmer's Statement on Reverse Side)

7194

7194

MAR - 6 1945

MAR - 2 1945

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 Albert G Hoppe

Licensed Embalmer No. 2971

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.