

S. No. 2  
OM-5-42  
Rev. 5-17-39  
PI X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34292  
State File No. ....  
Registrar's No. 794

FILED OCT 24 1944  
Registration District No. 128

Primary Registration District No. 2000

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:  
535 E. Pine Str  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 535 E. Pine Str.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Annie Wilkins  
(b) If veteran, name war.....  
(c) Social Security No. NONE

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct day 1  
year 1944 hour 5 minute 45 A.M.

4. Sex F.M. 5. Color Col. 6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife William Wilkins 6. (c) Age of husband or wife if alive 75 years  
7. Birth date of deceased UNK. UNK. 1852  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept. 25 1944 to Oct 1 1944  
that I last saw her alive on Sept 30 1944  
and that death occurred on the date and hour stated above.

8. AGE: Years 92 Months UNK. Days UNK. If less than one day  
hr. min.

Immediate cause of death Coronary Sclerosis  
Due to Chr. Hypertensive Cardic  
vasculopathy  
Due to.....

9. Birthplace UNK. Arkansas  
(City, town, or county) (State or foreign country)

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

10. Usual occupation Housewife  
11. Industry or business.....  
12. Name Unknown  
13. Birthplace UNK. UNK.  
(City, town, or county) (State or foreign country)  
14. Maiden name UNK.  
15. Birthplace UNK. UNK.  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations.....  
Of autopsy.....  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Florence Woolard  
(b) Address 625 Washington - Springfield, Mo  
17. (a) Burial (b) Date thereof Oct 4  
(Burial, cremation or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Lincoln Mem  
18. (a) Signature of funeral director W. P. Campbell  
(b) Address 867 Washington, Springfield, Mo  
19. (a) 19-7-44 (b) W. E. Handley  
(Date received local registrar) (Registrar's signature)

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)  
(e) Means of injury.....  
23. Signature Arthur O. Knapp (M. D. or other) MD  
Address 450 W. Capitol, Springfield, Mo. Date signed 10-3-44

984 (Licensed Embalmer's Statement on Reverse Side)

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**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 W. P. Campbell

Licensed Embalmer No. 1747

P. O. Address Springfield

**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.**