. No. 2
—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 1 1945

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13463

Primary Registration District No. 2000

Registrar's No. 356

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: BURGE HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 HR. (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: St Clair
(c) City or town: Brownington
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: KATHERINE LEE TUTER

3. (b) If veteran, name war: NONE

3. (c) Social Security No. NONE

4. Sex: FEMALE

5. Color or race: WHITE

6. (a) Single, widowed, married, divorced: SINGLE

6. (b) Name of husband or wife: NONE

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

7. Birth date of deceased: SEPT. (Month) 30 (Day) 1940 (Year)

8. AGE: Years 4 Months 6 Days 26 If less than one day hr. min.

9. Birthplace: Brownington (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: Child

11. Industry or business: At Home

MOTHER FATHER

12. Name: Henry Tuter

13. Birthplace: Brownington (City, town, or county) Mo. (State or foreign country)

14. Maiden name: Della Ware

15. Birthplace: Cusk (City, town, or county) Okla. (State or foreign country)

16. (a) Informant: Henry Tuter
(b) Address: Brownington, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr 28-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Harris Bend Cem

18. (a) Signature of funeral director: J. W. Klingner & Co
(b) Address: Springfield, Mo.

19. (a) 4-28-45 (Date received local registrar) (b) Dr W. S. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26 year 1945 hour 3 minute 05 P.M.

21. I hereby certify that I attended the deceased from April 26, 1945, to Apr. 26, 1945, that I last saw her alive on April 26, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Shock (Probable Cerebral Injury)

Due to: Automobile Accident

Due to:

Other conditions (Include pregnancy within 3 months of death): ADDITIONAL SUPPLEMENTARY INFORMATION

Major findings: Of operations: REQUESTED

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): Accident
(b) Date of occurrence: Apr. 26, 1945
(c) Where did injury occur? Near Glidewell Greene Missouri (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway, Highway #13 (Specify type of place)
While at work? NO (e) Means of injury: Auto Accident

23. Signature: Chas E. Berry (M. D. or other)
Address: Springfield, Mo. Date signed Apr. 27

(Licensed Embalmer's Statement on Reverse Side)

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 Ogle Stone Jr.

Licensed Embalmer No. 4176

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.

, No. 2B
M—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 856

SUPPLEMENTARY

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:
(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 (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Katherine L. Tuter

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept (Month) 30 (Day) 1940 (Year)

8. AGE: Years 4 Months 6 Days 26 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business

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

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

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Shock (Probable cerebral injury) — Duration

Due to Automobile Accident Non-Collision

Due to Bus Crowded Automobile off of Highway [illegible] embankment. (Highway [illegible] State maintained Highway)

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 17 oc 8

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) ACCIDENT
(b) Date of occurrence APR. 26 - 1945
(c) Where did injury occur? Near Glidewell Greene Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway #13 - State maintained (Specify type of place)
While at work? No (e) Means of injury AUTO

23. Signature James E D Ewry (M. D. or other)
Address Date signed

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