

No. 2
5-43
5-17-39
X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12871

FILED APR 24 1946

State File No.

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 327

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:
1920 W. Atlantic St., /
(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 Mo. (b) County Greene 39

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

(d) Street No. 1920 W. Atlantic St. 6
(If rural, give location) 0

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

If yes, name country _____

3. (a) PRINT FULL NAME DOVE HELEN GLIDEWELL WALTERS

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14
year 1946 hour 1 minute 30 P. M.

4. Female / 5. Color or race White

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

6. (b) Name of husband or wife Frank Walters

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased August 13, 1884
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Unattended by Physicians 19____; that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>61</u>	<u>8</u>	<u>1</u>	hr. _____ min. _____

Immediate cause of death probably Coronary Thrombosis

Due to _____

Due to _____

9. Birthplace Greene Co. Mo.
(City, town, or county) (State or foreign country)

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

Major findings:
Of operations _____

Of autopsy _____

10. Usual occupation House Wife

11. Industry or business At Home

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER {

12. Name James Robberson

13. Birthplace Unk. Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Mattie Gurley

15. Birthplace Unk. Unknown 9
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

16. (a) Informant Frank Walters

(b) Address Springfield, Mo.

(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? _____

17. (a) Burial (b) Date thereof 4-17-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Robberson Prairie Cem.

While at work? _____ (Specify type of place)

(e) Means of injury _____

18. (a) Signature of funeral director Franklingner & Co.

(b) Address Springfield, Mo.

19. (a) 4-15-46 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

23. Signature W. E. Handley Local registrar
(M. D. or other) _____
Address Springfield, Mo. Date signed 4-15-46

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

APR 26 1946

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.

Signature Roy A. Leavin
Licensed Embalmer No. 1763
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.

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