

FILED MAY 27 1946

State File No. _____

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 701

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: St Johns Hospital.
 (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)

3. (a) PRINT FULL NAME Clara Rosetta Fawcett.

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 Widow
 6. (b) Name of husband or wife H.V. Fawcett.
 6. (c) Age of husband or wife if alive DEC. years
 7. Birth date of deceased August 20, 1876
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	69	8	20	hr. _____ min. _____

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

10. Usual occupation Housewife
 At Home

11. Industry or business _____

12. Name Elishia B. Putman

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

14. Maiden name Miranda Wood
 (City, town, or county) (State or foreign country)

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

16. (a) Informant Harry B. Fawcett

(b) Address Springfield Mo.

17. (a) Burial (b) Date thereof May 12, 1946
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director J. W. Klingler & Co.
Springfield Mo.
 (b) Address _____
 19. (a) 5-13-46 (b) H. R. Handley
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39
 (c) City or town Fair Grove 0
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location) 0
No.
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10 - 1946
 year hour minute 00 A. M.

21. I hereby certify that I attended the deceased from April 23, 1946, to May 8, 1946
 that I last saw her alive on May 8, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Toxic nodular goiter
post death carcinomatous degeneration
 Due to _____
 Due to _____

Other conditions Myocarditis & probable coronary occlusion
 (Include pregnancy within 3 months of death)

Major findings: Toxic nodular goiter
Carcinomatous degeneration
 Of operations _____
 Of autopsy _____
 ADDITIONAL SUPPLEMENTAL INFORMATION REQUESTED

Duration 10 yrs

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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury 0

23. Signature F. W. Doubler (M. D. or other)
 Address Med. Arts. Springfield, Mo. Date signed 5/13/46

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

Way Rhodes

Licensed Embalmer No.

4071

P. O. Address

Springer

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

2B
45
43880

State File No. June
Registrar's No. 401

Registration District No. 128

Primary Registration District No. 2000

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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Clara R. Fawcett

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 wid

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Aug 20
(Month) (Day) (Year)

8. AGE: Years 69 Months 8 Days _____ (Less than one day _____) hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1942 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to Carcinoma primary in thyroid which was nodular & toxic

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature F J Dasher (M. D. or other) _____
Address _____ Date signed 5/29/46

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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

15189

16302