

S. No. 2
1-5-42
5-17-39
X32873

FILED SEP 11 1945 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No. 5463

Registrar's No.

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **SPRINGFIELD**
(c) Name of hospital or institution: **R.F.D. # 5**
(d) Length of stay: In hospital or institution. _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Greene**
(c) City or town **Springfield**
(d) Street No. **R.F.D. # 5**
(e) Citizen of foreign country? **No**
If yes, name country _____

3. (a) PRINT FULL NAME **MARGARET A. YOUNG BLOOD**

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. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **JAN. 1874**
(Month) (Day) (Year)

8. AGE: Years **71** Months **7** Days **1**
If less than one day _____ hr. _____ min.

9. Birthplace **MADISON CO. ARK.**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business **AT HOME**

12. Name **J.C. HINDS**

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

14. Maiden name **BONHAM**

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

16. (a) Informant **Mrs. Inez Hinds**

(b) Address **Springfield Mo. R#5**

17. (a) **Burial** (b) Date thereof **Aug 17-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **East Lawn Cem.**

18. (a) Signature of funeral director **J. W. Klingner Co**

(b) Address **Springfield Mo.**

19. (a) **Aug 16, 1945** (b) **Mrs. Porter O'Neil**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **13th**
year **1945** hour **11** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **Jan 1944** to **July 14 1945**
that I last saw him or her alive on **about Jan 1 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Arterial Embolism**
Due to **Arterio-sclerosis**

Due to _____

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

Major findings: Of operations **JCB**

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? **0**

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

23. Signature **Max [unclear]** (M. D. or other) **MD**

Address **Springfield Mo.** Date signed **8-14-45**

Duration

per minute

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

Greene County Health Office,

County File Number 46-9-107

Date Filed 9-10-46

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..... *J. B. Klingner*.....
Licensed Embalmer No. 3358
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.