

Registration District No. **318**

Primary Registration District No. **2001**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(c) Name of hospital or institution: **1030 S. WELLS**
(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. **1030 S. Wells**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME **LYDIA ANN WESTERFIELD**
3. (b) If veteran, name war **NONE**
3. (c) Social Security No. **NONE**

20. DATE OF DEATH: Month **Sept.** day **1** year **1941** hour **6** minute **30 P. M.**

21. I hereby certify that I attended the deceased from **July 25** 19**41**, to **September 1** 19**41**; that I last saw her alive on **August 13** 19**41**; and that death occurred on the date and hour stated above.

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **E.A. WESTERFIELD**
6. (c) Age of husband or wife if alive **73** years
7. Birth date of deceased **April 22 1871**
(Month) (Day) (Year)

Immediate cause of death **Uremia**

8. AGE: Years **70** Months **4** Days **9** If less than one day _____ hr. _____ min.

Due to **Pyelonephrosis**
Due to _____
Other conditions **Hypertension**
(Include pregnancy within 3 months of death)

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

10. Usual occupation **Housewife**

11. Industry or business **In home**

12. Name **Alfred Harrison**

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

14. Maiden name **Margaret Christian**

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

16. (a) Informant **E.A. Westerfield**

(b) Address **1030 S. Wells, Springfield, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Dec 3-1941**
(Month) (Day) (Year)

(c) Place: burial or cremation **Nowata, Okla**

18. (a) Signature of funeral director **W. H. ... & Co.**

(b) Address **Springfield, Mo.**

19. (a) **Dec 7-1941** (Date received local registrar) (b) **W. E. Handley MD** (Registrar's signature)

Major findings: Of operations **None.**
Of autopsy **None.**

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 **8**
23. Signature **Dr. R. W. ...** (M. D. or other) _____
Address **Springfield, Mo.** Date signed **9-2-41**

Duration
3 weeks.
more than
4 weeks.
Unknown
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MAY 26 1942

919

MAY 17 1942

JAN 4 1944

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 *Miss Catherine Stinger*

Licensed Embalmer No. *3719*

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.