

~~FILED~~ OCT 5 1942

Registration District No. 25

Primary Registration District No. 5460

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield, R.R. 8
(c) Name of hospital or institution: Rural Clay Township
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 60 yrs
In this community 60 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Lorinda Stiffles

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, Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased March 19 1864
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 24
If less than one day hr. min.

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

10. Usual occupation House Keeper

11. Industry or business

12. Name Alvin Nelson

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

14. Maiden name Mamie Robinson

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

16. (a) Informant John Blakes

(b) Address Springfield, Mo.

17. (a) Buried (b) Date thereof Sept 14 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Patterson Cemetery

18. (a) Signature of funeral director T. B. Chubb

(b) Address Springfield, Mo.

19. (a) 4/17-422 (b) Mrs. Frank Smith
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12 year 1942, hour 8 minute 10 P.M.

21. I hereby certify that I attended the deceased from 9-9-1942 to 9-12-1942, 1942
that I last saw her alive on 9-12-1942
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebro Hemorrhage

Due to

Due to

Other conditions: 830
(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 W. Kelly (M. D. or other)

Address Springfield, Mo. Date signed 9-16-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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

T. B. Chaffin

Licensed Embalmer No. *2192*

P. O. Address. *Ozark, 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.