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7-39  
K23630

FILED JAN 25 1944

State File No. \_\_\_\_\_

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 61

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield MO.

(c) Name of hospital or institution: 633 W. CENTRAL  
(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  
(If outside city or town limits, write "RURAL")

(d) Street No. 633 W. CENTRAL  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ELLEN S. BERNETT

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15  
year 1944 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from 12-15-44  
to 1-14-44

that I last saw her alive on January 14 8  
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 WIDOW

6. (b) Name of husband or wife unk

6. (c) Age of husband or wife if alive unk years 3 1856 (Day) (Year)

7. Birth date of deceased Jan (Month) 3 (Day) 1856 (Year)

Immediate cause of death Myocardial Insufficiency

Due to Arteriosclerosis

Duration 2 mo. 9.

8. AGE: Years 88 Months 0 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

9. Birthplace unk. North Carolina (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business at home

12. Name Ely Spoon

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

14. Maiden name unk. unknown

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

16. (a) Informant Stella Sillery

(b) Address SPRINGFIELD MO.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Jan 17 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Clear Creek Cem.

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

(b) Address SPRINGFIELD MO.

19. (a) 1-14-44 (Date received local registrar)

(b) 5079 Handley (Registrar's signature)

PHYSICIAN 932

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)

(c) Means of injury \_\_\_\_\_

23. Signature E. Sillery Other \_\_\_\_\_

Address SPRINGFIELD MO. Date signed 1-17

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

**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 *C. G. Stone Jr.*  
Licensed Embalmer No. *4776*  
P. O. Address *Springfield*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

X