

FILED SEP 3 1944

State File No.

Registrar's No. 678

Registration District No. 128

Primary Registration District No. 5000

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:
Burger-Connelly Rest Home, 1033 C Perry
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Weeks
(Specify whether years, months or days)

In this community 4 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield
(If outside city or town limits, write "RURAL")

(d) Street No. Donovan Hotel
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Herschel L. Rawlings

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Helen Rosemary Rawlings 6. (c) Age of husband or wife if alive wife years

7. Birth date of deceased July 30, 1861
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>83</u>	<u>0</u>	<u>19</u>		hr. min.

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

10. Usual occupation Retired Conductor

11. Industry or business Frisco R.R.

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Helen R. Rawlings

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 8/21/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director H. H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 8-23-44 (b) H. W. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 19
year 1944 hour 7 minute 25 p.M.

21. I hereby certify that I attended the deceased from Apr 1 1944 to Aug 7 1944
that I last saw him alive on Aug 7 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage 48 hrs
Chronic hypertensive 7 yrs
cardiovascular disease

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Other conditions (Include pregnancy within 3 months of death)

Major findings: 93d

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 (Specify)

23. Signature Arthur D. Knabb M.D. or other MD

Address 450 E. Com. St. Date signed 8-23-44

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

MOTHER FATHER

JUL 9 1952

SEP 26 1949

SEP 1 1948

OCT 5 1948

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.....

Licensed Embalmer No.....

P. O. Address.....

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.