

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 30 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **198**

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

9
2
6

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:
1605 W. ELM ST. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **GREENE**
(c) City or town **SPRINGFIELD**
(If outside city or town limits, write "RURAL")
(d) Street No. **1605 W. ELM ST.**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **MATTIE D. STEWART.**

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. (b) Name of husband or wife **UNK.** 6. (c) Age of husband or wife if alive **Dec. 1858**
7. Birth date of deceased **NOV. 18**
(Month) (Day) (Year)

8. AGE: Years **86** Months **3** Days **20** If less than one day hr. min.

9. Birthplace **MT. EDEN KY. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business **AT HOME**

12. Name **ELIJAH RICHARDSON**

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

14. Maiden name **MARGARET HICKMAN**

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

16. (a) Informant **Mrs. Helen Rosenberg**

(b) Address **SPRINGFIELD MO.**

17. (a) **Burial** (b) Date thereof **Mar 10-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hazelwood Cem. Springfield MO.**

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

(b) Address **SPRINGFIELD MO.**

19. (a) **3-9-45** (b) **W. H. Hensley**
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **8**
year **1945** hour **3** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **March 6**, 19**45** to **March 8-45**, 19**45**, that I last saw her alive on **March 6**, 19**45**, and that death occurred on the date and hour stated above.

Immediate cause of death: **Cerebral Dementia**

Due to **of 30'**

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings: Of operations **No**
Of autopsy **No**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **No**

(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 **None**

23. Signature **Robert Williams** (M. D. or other)

Address **SPRINGFIELD MO.** Date signed **3-9-45**

Duration **2 Days**

PHYSICIAN
Underline the cause to which death should be charged statistically.

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.

X