

FILED MAY 11 1945
Registration District No. _____

Primary Registration District No. **2000**

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

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **SPRINGFIELD**
(c) Name of hospital or institution: **CITY HOSPITAL**
(d) Length of stay: In hospital or institution **12 hrs.**
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. **855 S. Main**
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **INFANT COKER**

(b) If veteran, name war **None** (c) Social Security No. **none**

4. Sex **Female?** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **Single**

(b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive, _____ years

7. Birth date of deceased **APRIL 30, 1945**
(Month) (Day) (Year)

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

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

10. Usual occupation **Infant**

11. Industry or business _____

12. Name **ED COKER**

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

14. Maiden name **NINA CARLOCK**

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

16. (a) Informant **MRS NINA COKER**

(b) Address **855 - S. MAIN, Spfld., Mo.**

17. (a) **BURIAL** (b) Date thereof **MAY 9 - 45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **HAZLEWOOD**

18. (a) Signature of funeral director **Herbert Y. Smith**

(b) Address **702 - 24 - Jefferson Spfld.**

19. (a) **5-1-45** (b) **S. W. S. Handley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **30** year **1945** hour **5:00** minute _____ P.M.

21. I hereby certify that I attended the deceased from **April 30**, 1945, to **April 30**, 1945, that I last saw her alive on **April 30**, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**
Due to **8 months Conception**
Due to _____

Duration

12 hrs

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

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) (e) Means of injury _____

23. Signature **E. W. S. Handley** Date signed **5-1-45**
Address **Medical Apts Bldg., Spfld., Mo.**

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.

x