S. No. 2
I—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 2 1945

Registration District No. 12

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Rosberry

State File No. 13475

Primary Registration District No. 2000

Registrar's No. 307

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: Spfd. Baptist Hosp. (If not in hospital or institution, write street number or location)

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

In this community: 3 Days

2. USUAL RESIDENCE OF DECEASED: Greene

(a) State: Missouri (b) County: ~~Lawrence~~ 39

(c) City or town: Ash Grove, Rural 1 (If outside city or town limits, write "RURAL")

(d) Street No.: 0 (If rural, give location)

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

If yes, name country:

3. (a) PRINT FULL NAME: Nettie Wilson

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Female /

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married /

6. (b) Name of husband or wife: Otis G. Wilson

6. (c) Age of husband or wife if alive: 69 years

7. Birth date of deceased: May (Month) 17, (Day) 1886 (Year)

8. AGE: Years	Months	Days	If less than one day
✓ 68	10	24	hr. min.

9. Birthplace: Rossville (City, town, or county) Kansas / (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Archie Abbott
13. Birthplace: Kingston (City, town, or county) Canada ? (State or foreign country)

MOTHER
14. Maiden name: Unk Fields
15. Birthplace: Havenville (City, town, or county) Canada ? (State or foreign country)

16. (a) Informant: Otis G. Wilson

(b) Address: Ash Grove, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 4/12/45 (Month) (Day) (Year)

(c) Place: burial or cremation: Waynesville, Mo.

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

(b) Address: Springfield, Mo.

19. (a) 4-12-45 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: April day: 11 year: 1945 hour: 6:00 minute: a. M.

21. I hereby certify that I attended the deceased from Apr. 9, 1945, to April 11, 1945, that I last saw her alive on April 10, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary occlusion	
Due to:	
Due to:	
Other conditions: Diabetes mellitus (Include pregnancy within 3 months of death) Hyperthyroidism	
Major findings: Of operations: No operation	
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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: [illegible] (M. D. or other)

Address: 618 Woodruff Bldg. Date signed: 4/12/45

(Licensed Embalmer's Statement on Reverse Side)

Spfd., 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.