

FILED JUN 26 1945
128

Registration District No.

Primary Registration District No. 2000

Registrar's No. 457

1. PLACE OF DEATH: **GREENE**

(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:
1017 E. COMMERCIAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
In this community **73 YR. 3 MO. 3 DAYS** (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. **1017 E. Commercial**
(If rural, give location)

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

3. (a) PRINT FULL NAME **EMMA R. SCHOFIELD**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color of race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **ALBERT L. SCHOFIELD** 6. (c) Age of husband or wife if alive **73** years **1872**

7. Birth date of deceased **MARCH 1** (Month) **1872** (Day) (Year)

8. AGE: Years **73** Months **3** Days **3** If less than one day **hr. min.**

9. Birthplace **GREENE CO. MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business **AT HOME**

MOTHER FATHER { 12. Name **BERNARD F. RATHBONE**

13. Birthplace **BIRMINGHAM ENGLAND**
(City, town, or county) (State or foreign country)

14. Maiden name **EMILY RUSH WOODS**

15. Birthplace **GREENE CO. MO.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Albert L. Schofield**

(b) Address **Springfield Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **June 6 1945**
(Month) (Day) (Year)

(c) Place: burial or cremation **East Lawn Cem**

18. (a) Signature of funeral director **J. W. Kingner Co.**

(b) Address **Springfield Mo.**

19. (a) **6-5-45** (Date received local registrar) (b) **J. W. Kingner** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **4** year **1945** hour **4** minute **30 A.** M.

21. I hereby certify that I attended the deceased from **May 1**, 19**45**, to **June 4**, 19**45**; that I last saw her alive on **June 2**, 19**45**; and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary - Renal - Venous thrombosis**

Due to **Arteriosclerosis**

Due to **131a**

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 **Max Pitt** (M.D. or other) **MO.**

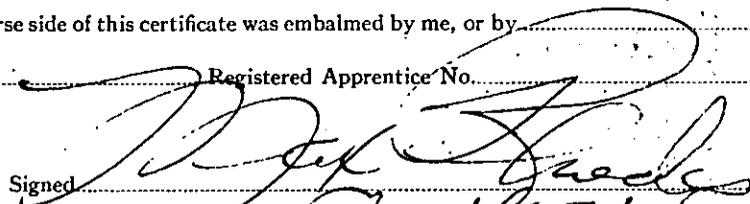
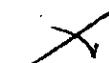
Address **Springfield, Mo.** Date signed **6-5-45**

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

FEB 14 1947

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. 4071
P. O. Address Springfield


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.