

FILED NOV 13 1945

Registration District No. 28

Primary Registration District No. 2000

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: Bunge Hospital 13
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 hours
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39

(c) City or town Springfield 20
(If outside city or town limits, write "RURAL")

(d) Street No. 914 E. Pacific
(If rural, give location), _____

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

3. (a) PRINT FULL NAME BEULAH BELT

3. (b) If veteran, name war NONE

3. (c) Social Security No. LNK

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22
year 1945 hour 7 minute 10 A.M.

21. I hereby certify that I attended the deceased from 10-17
1945 to 10-22, 1945
that I last saw her alive on 10-22, 1945
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife DENNIS BELT

6. (c) Age of husband or wife if alive 48 years 1913
(Month) (Day) (Year)

7. Birth date of deceased March 9
(Month) (Day) (Year)

Immediate cause of death _____
Myo Cardial insufficiency

Due to Glomerular nephritis wk

Due to Uremia 1 da

Other conditions (Include pregnancy within 3 months of death) _____

8. AGE:	Years	Months	Days	If less than one day
✓	<u>32</u>	<u>7</u>	<u>13</u>	hr. _____ min. _____

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

10. Usual occupation House wife

11. Industry or business at Home

12. Name Pete Uasery

13. Birthplace LNK Mo 0
(City, town, or county) (State or foreign country)

14. Maiden name Wanda (LNK)

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

16. (a) Informant Dennis Belt

(b) Address Springfield Mo

17. (a) Burial (b) Date thereof Oct. 25, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem

18. (a) Signature of funeral director J.W. Klingner & Co

(b) Address Springfield Mo

19. (a) 10-25-45 (b) R.M. Staudley
(Date received local registrar) (Registrar's signature)

Major findings: _____
Of operations _____

Of autopsy 130

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 [Signature] _____
Address Springfield, Mo Date signed 10-23-45

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

9
2
6

984

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..... *Ogle Stone Jr.*.....
Licensed Embalmer No..... *4176*.....
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.