

FILED NOV 13 1945
Registration District No. 228

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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hosp. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 Hours
In this community 62 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 3
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 559 St. Louis
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Adele Diggins

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 Widowed
(b) Name of husband or wife A.B. Diggins 6. (c) Age of husband or wife if alive Dec. 1865 years
7. Birth date of deceased Nov. 29, 1865
(Month) (Day) (Year)

8. AGE: Years 79 Months 10 Days 27 If less than one day hr. min.

9. Birthplace Brunswick Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER { 12. Name Louren Bostworth
13. Birthplace UNK. Pennsylvania 1
(City, town, or county) (State or foreign country)
14. Maiden name Catherine E. Price
15. Birthplace Unknown Unknown 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Max Fulbright
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 10/18/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 10-18-45 (b) H. W. Hagedorn
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 17
year 1945 hour 6 minute 45a. M.

21. I hereby certify that I attended the deceased from Sept. 30 1945 to Oct. 16 1945
that I last saw her alive on Oct. 16 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration 2 wks

Due to Atherosclerosis

Due to _____

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 St. P. Maresca (M. D. or other) _____
Address Springfield, Mo. Date signed 10/18/45

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

Walter E. Hamell

Licensed Embalmer No.

3808

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