

S. No. 2
M-2-43
7-5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41245

State File No.

Registrar's No. 984

Registration District No. 128

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:
Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether
 In this community 2 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Greene 39
 (c) City or town Springfield 2
(If outside city or town limits, write "RURAL")
 (d) Street No. 1406 W. Webster 6
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Ollie Miller
 3. (b) If veteran, name war None
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month December day 1
 year 1945 hour 6:15 minute P M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife August F. Miller
 6. (c) Age of husband or wife if alive Unknown years
 7. Birth date of deceased July 23, 1886
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 16, 1945 to Dec 1, 1945
 that I last saw her alive on Dec 1, 1945
 and that death occurred on the date and hour stated above.

8. AGE: Years 59 Months 4 Days 8
 If less than one day _____ hr. _____ min.

Immediate cause of death Coronary Thrombosis 2d
 Duration _____

9. Birthplace Mountain View, Missouri
(City, town, or county) (State or foreign country)

Due to _____
 Due to _____

10. Usual occupation Housewife

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

11. Industry or business In Home
 12. Name John Thomas
 13. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)
 14. Maiden name UNK.
 15. Birthplace UNK. a
(City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. August Miller
 (b) Address Springfield, Missouri
 17. (a) Burial (b) Date thereof Dec. 3, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Green Lawn Cemetery

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? _____

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
Springfield, Missouri
 (b) Address _____

While at work? _____
(Specify type of place) (e) Means of injury.

19. (a) 12-4-45 (b) Dr. W. Handley
(Date received local registrar) (Registrar's signature)

23. Signature Dr. P. Wadsworth (M. D. or other) _____
 Address Springfield, Mo Date signed 12-4-45

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 *Lewis G. Scharpf*.....

Licensed Embalmer No *3802*.....

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.