S. No. 2
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 23 1946

State File No. 30037

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 740

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: 223 Hayden (residence) /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... 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. 223 Hayden 6
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME BELL R. THOMPSON

3. (b) If veteran, name war None

3. (c) Social Security No. UNK.

4. Sex female /

5. Color or race white

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

6. (b) Name of husband or wife Chas. C. Thompson

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

7. Birth date of deceased November 9, 1869 (Month) (Day) (Year)

8. AGE: Years 76 Months 10 Days 0 If less than one day ..... hr. ..... min.

9. Birthplace Colluater, Arkansas / (City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business .....

FATHER
12. Name John Laye
13. Birthplace UNK. Arkansas / (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Martha Hawkins
15. Birthplace UNK. Arkansas / (City, town, or county) (State or foreign country)

16. (a) Informant Chas. C. Thompson
(b) Address 223 Hayden, SPFD., MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/1946 (Month) (Day) (Year)
(c) Place: burial or cremation GREENLAWN CEMETERY

18. (a) Signature of funeral director ALMA LOHMEYER FUNERAL HOME
(b) Address SPRINGFIELD, MISSOURI

19. (a) 9-11-46 (Date received local registrar) (b) W E Handley M D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 9 year 1946 hour 2:15A.M. minute ..... M.

21. I hereby certify that I attended the deceased from Sept 1, 1946 to Sept 9, 1946 that I last saw her alive on Sept 8, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	10 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

83A

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 0

23. Signature T S Bruton (M. D. or other) M.D.

Address Springfield, Mo. Date signed 9/10/46

(Licensed Embalmer's Statement on Reverse Side)

AUG 30 1948

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.....L. A. Roof.....

Licensed Embalmer No.....3044.....

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