

S. No. 2  
M-5-43  
v. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JAN 9 1947**  
**128**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40273**  
Registrar's No. **1040**

Registration District No. \_\_\_\_\_ Primary Registration District No. **2000**

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

39087

**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: **Burge Hospital 0**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **18 days**  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo.** (b) County **Greene** **31**

(c) City or town **Springfield** **2**  
(If outside city or town limits, write "RURAL")

(d) Street No. **1631 N. Clay** **6**  
(If rural, give location) **0**

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

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **Wella May Strader**

**3. (b) If veteran, name war** \_\_\_\_\_ **3. (c) Social Security No.** \_\_\_\_\_

**4. Sex** **F** **5. Color or race** **W**

**6. (a) Single, widowed, married, divorced** **Married**

**6. (b) Name of husband or wife** **James Strader** **6. (c) Age of husband or wife if alive** **80** years

**7. Birth date of deceased** **Sept. 10 1868**  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **Dec.** day **23** year **1946** hour **11** minute **20** P. M.

**21. I hereby certify that I attended the deceased from** **Dec 5**, 19**46** to **Dec 23**, 19**46**  
that I last saw her alive on **Dec 23**, 19**46**  
and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
<b>78</b>	<b>3</b>	<b>13</b>	hr. min.

Immediate cause of death: **Pneumonia, hypostatic** **4 days**

Due to: **Fracture, intertrochanteric rt. femur** **18 days.**

Due to: **Senility**

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

**10. Usual occupation** **?**

**11. Industry or business** **?**

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.

**MOTHER, FATHER**

**12. Name** **Frank O. Kelly**

**13. Birthplace** **not known** **Texas**  
(City, town, or county) (State or foreign country)

**14. Maiden name** **Elsie Smith**

**15. Birthplace** **not known** **Texas**  
(City, town, or county) (State or foreign country)

**22. If death was due to external causes, fill in the following:**

(a) Accident, suicide, or homicide (specify) **Accident 133**

(b) Date of occurrence **Dec 5, 1946**

(c) Where did injury occur? **Springfield Greene Mo**  
(City) (Town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**In home - slipped and fell on floor**  
(Specify type of place) (e) Means of injury **fall 0**

While at work? \_\_\_\_\_

**23. Signature** **Don J. Selaby** (M. D. or other) **M.D.**  
Address **Springfield, Mo.** Date signed **12-26-46**

**16. (a) Informant:** **Harry Nicholson**

(b) Address **1631 N. Clay**

**17. (a) Burial** (b) Date thereof **12/26/1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Park Cemetery**

**18. (a) Signature of funeral director** **ALMA LOHMEYER FUNERAL HOME**  
**Springfield, Missouri**

(b) Address \_\_\_\_\_

**19. (a) 13-26-46** (b) **W. H. Hasty**  
(Date received local registrar) (Registrar's signature)

---

---

**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.....

*C. A. Rauf*

Licensed Embalmer No. 3044

P. O. Address Springfield, Missouri

**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.**