

FILED MAR 28 1947
Registered District No. _____

Primary Registration District No. 2100

Registrar's No. 214

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 Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days
(Specify whether _____)
In this community 90 Days
years, months or days

3. (a) PRINT FULL NAME Sue Boyle Saunders
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
6. (b) Name of husband or wife George B. Saunders
6. (c) Age of husband or wife if alive Dec. years
7. Birth date of deceased? unknown
(Month) (Day) (Year)

8. AGE: Years 53 Months 9 Days 8
If less than one day hr. min.

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

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER
12. Name Anthony Boyle
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Katherine Clark
15. Birthplace GA
(City, town, or county) (State or foreign country)

16. (a) Informant M.F. Boyle
(b) Address Springfield, Mo.
17. (a) Burial (b) Date thereof 3-11-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary
18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.
19. (a) 3-12-47 (b) W.S. Laidley md
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 39
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 945 W. Lynn
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9
year 1947 hour 1 minute 05a. M.

21. I hereby certify that I attended the deceased from 3/3 1947 to 3/9 1947
that I last saw her alive on 3/8 1947
and that death occurred on the date and hour stated above.
Immediate cause of death richly failure due to pyelonephritis

Due to Hypertensive heart disease with myocardial failure.
Due to _____

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

Major findings: 93P
Of operations _____
Of autopsy _____

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)
Means of injury _____
23. Signature W. Peland Langston (M. D. or other) me
Address Springfield Date signed 3/11/47

Duration of illness 5-6 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

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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. Hammett*

Licensed Embalmer No. *3898*

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.

Registration District No. 128

Primary Registration District No. 2000

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Sue B. Saunder
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 wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased unk (Month) (Day) (Year)

8. AGE: Years 53 Months _____ Days _____ (If less than one day, hr. min.)
9. Birthplace unk (City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

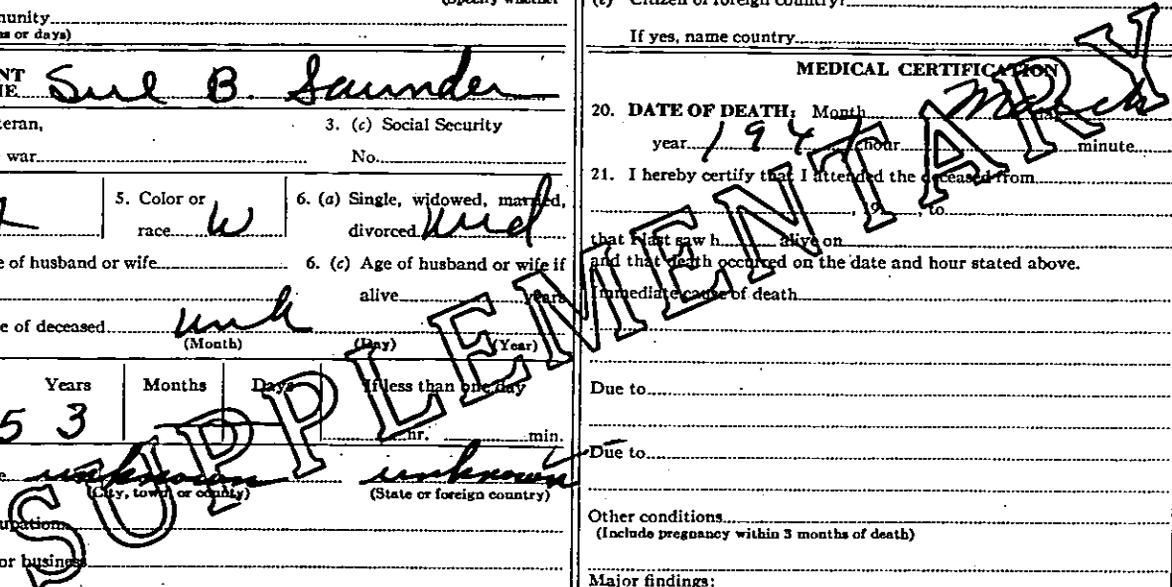
16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) 3-12-47 (b) W. J. Handley MD
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Due to _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____



MOTHER FATHER

DEPARTMENT RECORD

8070