

FILED MAY 20 1947

Registration District No. 7128

Primary Registration District No. 5466

Registrar's No. 399

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield - Rural S. Campbell  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Ozark Osteopathic Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11 days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howell  
(c) City or town West Plains, Missouri  
(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 May day 1  
year 1947 hour 7:15 minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from April 20  
1947 to May 1 1947;  
that I last saw her alive on May 1 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cholera Duration \_\_\_\_\_

Due to Cholera

Due to \_\_\_\_\_  
Other conditions Thyroidectomy 127A  
(Include pregnancy within 7 months of death)

Major findings: Cholera  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Signature of physician 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)  
Means of injury \_\_\_\_\_

23. Signature William H. Steinhilber (M. D. or other) \_\_\_\_\_  
Address Springfield Mo Date signed May 1/47

3. (a) PRINT FULL NAME Hattie Estelle East

3. (b) If veteran, name war No 3. (c) Social Security No. Unknown

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Joseph East 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased November 25 1888  
(Month) (Day) (Year)

8. AGE: Years 58 Months 5 Days - If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Walter P. Stever

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Isabel Chidester

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Chester Hart

(b) Address 3519 East Spruce, Seattle, Washington

17. (a) Burial (b) Date thereof 5-3-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Meady, Mo

18. (a) Signature of funeral director Ward - Schupp  
(b) Address Springfield, Mo

19. (a) 5-3-47 (b) W E Handley md  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

MAY 21 1940

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. Schupp*.....  
Licensed Embalmer No. *3802*  
P. O. Address *Spangfield, Ma*

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.