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7-5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

UNITED STATES DEPARTMENT OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JUN 11 1947

Registration District No. 243 Primary Registration District No. 4364 Registrar's No. 22

1. PLACE OF DEATH:  
(a) County Newton  
(b) City or town Stella, Mo.  
(c) Name of hospital or institution: Cardwell Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 24 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Newton 73  
(c) City or town Stella Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Cleta Carolene Springer  
(b) If veteran, name war no  
(c) Social Security No. no

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 12 year 1947 hour 5:08 minute P.M.

4. Sex female 5. Color or race white  
6. (a) Single, widowed, married, divorced 0  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 25, 1938  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 18, 1947 to May 12, 1947  
that I last saw her alive on May 12, 1947  
and that death occurred on the date and hour stated above.  
Immediate cause of death abdominal abscess Duration 2 months

8. AGE: Years 8 Months 11 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to uncomplicated lymphatic peritonitis Duration 2 wks.  
Due to \_\_\_\_\_

9. Birthplace Stella - Newton Mo.  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 5 months of death) \_\_\_\_\_

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name Clarence J Springer  
13. Birthplace Iowa  
(City, town, or county) (State or foreign country)  
14. Maiden name Mildred Bikes  
15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

Major findings: 74A  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Clarence J Springer  
(b) Address Stella Mo. R.R.  
17. (a) Burial (b) Date thereof May 14-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Rocky Comfort  
18. (a) Signature of funeral director Wheaton Funeral Home  
(b) Address Wheaton Mo  
19. (a) June 1, 1947 (b) Alpha Dyer  
(Date received local registrar) (Registrar's signature)

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 0  
23. Signature Cardwell (M. D. or other) 0  
Address Stella Mo. Date signed 5/16/47

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

MOTHER FATHER

**RECEIVED**

District Health Officer No. Newton  
District File Number 6-47-112  
Date Filed 6-9-47

**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 G. E. Culver

Licensed Embalmer No. 2584

P. O. Address Cassville 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.**