

S. No. 2
-12-45
5-17-39
I X47070

FILED SEP 15 1947
Registration District No. 128

Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County Springfield

(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
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Approx 3 hr.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39

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

(d) Street No. 2118 N. Missouri 6
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Carol Weane Sawyers

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 / 5. Color or race WHITE

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Aug 30 1947
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>0</u>	<u>0</u>	<u>3 hr. 15 min.</u>

9. Birthplace Springfield Mo. - 0
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business Infant

12. Name Robert Weane Sawyers

13. Birthplace Springfield Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Sue Carol Smith

15. Birthplace Springfield Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Robert W. Sawyers

(b) Address 2118 N. Missouri

17. (a) Burial (b) Date thereof 8/31/47
(City, town, or county) (Month) (Day) (Year)

(c) Place: burial or cremation Hobbes Prairie

18. (a) Signature of funeral director J. W. Klingner & Co.

(b) Address Springfield Mo

19. (a) 9-2-47 (b) W. E. Handley, Jr.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 30
year 1947 hour 12 minute 15 P. M.

21. I hereby certify that I attended the deceased from Aug 30 1947 to Aug 30 1947
that I last saw her alive on Aug 30 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity at 7 mo -

Due to _____

Due to _____

Other conditions 159
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration _____

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)
(c) Cause of injury _____

23. Signature Arthur H. Kraft (D. or other) MD

Address 400 W. 2nd St. Springfield Date signed 9-2-47

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

Max Rhodes

Licensed Embalmer No.

4071

P. O. Address

Springfield

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.