

FILED NOV 29 1948

Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **1032**

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: **1216 W. Walnut**
Crane Rest Home
(If not in hospital or institution, write street number or location) **4**
(d) Length of stay: In hospital or institution **7 weeks** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Judy C. Kaller (Roller)**

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

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

6. (b) Name of husband or wife **Chazy Kaller** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Dec 18 - 1849**
(Month) (Day) (Year)

8. AGE: Years **98** Months **10** Days **18** If less than one day hr. _____ min. _____

9. Birthplace **Lawrence co. mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Home wife**

11. Industry or business _____

MOTHER FATHER

12. Name **Bill Manning**

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

14. Maiden name **Wakarusa**

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

16. (a) Informant **Judy Kaller**

(b) Address **Springfield mo**

17. (a) **Removal** (b) Date thereof **11-26-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Crane mo**

18. (c) Signature of funeral director **Chazy H. manbra**

(b) Address **crane mo**

19. (a) _____ (b) **W.E. Hardley MD**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **Stone 104**
(c) City or town **crane**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **1**
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **24**
year **1948** hour **9** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **Nov 23**, 1948 to **Nov 26**, 1948
that I last saw ~~her~~ alive on **Nov 23**, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Thrombosis** Duration **4 days**

Due to **Fracture of Hip 7 weeks**

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) **accident**

(b) Date of occurrence **October 6, 1948**

(c) Where did injury occur? **Crane - Stone Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Home**
While at work? **no** (Specify type of place) (e) Means of injury **Fall**

23. Signatures **J.B. Britton** (M. D. or other) **MD**
Address **Springfield mo** Date signed **11/27/48**

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

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

George H. Manlove

Licensed Embalmer No. *3827*

P. O. Address *Crane 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.