

Registration District No. **318** Primary Registration District No. **2001**

1. PLACE OF DEATH:

(a) County **Greene**  
(b) City or town **Springfield**  
(c) Name of hospital or institution **909 N. Freemont**  
(d) Length of stay: In hospital or institution **6 1/2** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **BELLE M. MARSHALL**

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 **Widow**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife If alive \_\_\_\_\_ years

7. Birth date of deceased **Jan 20 1867**  
(Month) (Day) (Year)

8. AGE: Years **72** Months **10** Days **3** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **House wife**

11. Industry or business **In home**

12. Name **Stokes Clodfelter**

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

14. Maiden name **Mary Bird** (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature **Brynn Marshall**

(b) Address **Springfield, Mo**

17. (a) **Burial** (b) Date thereof **Nov 28 1939**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn Cemetery**

18. (a) Signature of funeral director **Lo W. Klingner**

(b) Address **Springfield, Mo**

19. (a) **11-27-39** (b) **Chas. A. George**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Greene**  
(c) City or town **Springfield**  
(d) Street No. **909 N. Freemont**  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **23rd** year **1939** hour **9** minute **159** M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to **Nov. 23**, 19**39**  
that I last saw her alive on **Nov. 23**, 19**39**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute cardiac dilatation** Duration **2 hrs**

Due to **Chronic hypertensive car-  
diovascular disease**

Due to \_\_\_\_\_

Other conditions: **9562**  
(Include pregnancy within 3 months of death)

Major findings: **9562**  
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 **Arthur Marshall** (M. D. or other) **M.D.**

Address **Springfield, Mo.** Date signed **11/24/39**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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 *William Gray*.....

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, above space should be left blank.**