

Registration District No. \_\_\_\_\_ Primary Registration District No. 2000

1. PLACE OF DEATH:  
(a) County GREENE  
(b) City or town SPRINGFIELD  
(c) Name of hospital or institution: 2035 TAYLOR  
(d) Length of stay: \_\_\_\_\_  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME ELLA A. WILLEAMS  
3. (b) If veteran, name war NONE  
3. (c) Social Security No. NONE

4. Sex FEMALE  
5. Color or race WHITE  
6. (a) Single, widowed, married, divorced WIDOW  
6. (b) Name of husband or wife Unknown  
6. (c) Age of husband or wife if alive Dec years  
7. Birth date of deceased JAN 12 1853

8. AGE:	Years	Months	Days	If less than one day
✓	89	11	8	hr. min.

9. Birthplace HAGUE NEW YORK  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business In home

MOTHER FATHER  
12. Name J.E. Phillips  
13. Birthplace Unknown Unknown  
14. Maiden name Unknown  
15. Birthplace Unknown Unknown

16. (a) Informant Mrs. M. V. Berry  
(b) Address Springfield, Mo.  
17. (a) Burial (b) Day thereof 12-22-42  
(c) Place: burial or cremation East Lawn Cem.

18. (a) Signature of funeral director J. W. Kingner & Co.  
(b) Address Springfield, Mo.  
19. (a) 12-21-42 (b) J. W. Kingner & Co.  
(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. 2035 TAYLOR  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month DEC day 20 year 1942 hour 8 minute 30 A.M.  
21. I hereby certify that I attended the deceased from 1933 to 12-20 1942  
that I last saw h. ER alive on 12-16 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Embolism  
Duration 10 min.

Due to Cardio-Renal-Vascular Disease  
Due to \_\_\_\_\_

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

Major findings: 13/a  
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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature Max S. King (M. D. or other) M.D.  
Address Springfield, Mo. Date signed 12-24-42

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.....

*Max Rhodes*  
4071  
Licensed Embalmer No.....  
P. O. Address.....  
*Springfield*  
*St.*

**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.**