No. 2
9-4-41
17-39
X29484

Dr. Beatie

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6351

FILED MAR 6 1943 128

Registration District No. ____ Primary Registration District No. 2000 Registrar's No. 123

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

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: Burge Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 Month (Specify whether years, months or days)

In this community: 30 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene

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

(d) Street No.: 1052 W. Harrison (If rural, give location)

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

If yes, name country: 0

3. (a) PRINT FULL NAME: Alice Kernen

3. (b) If veteran, name war: no

3. (c) Social Security No.: no

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: Albert Kernen

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

7. Birth date of deceased: Dec. (Month) 9 (Day) 1865 (Year)

8. AGE: Years 77 Months 2 Days 0 If less than one day ____ hr. ____ min.

9. Birthplace: Highlandville (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Home

11. Industry or business: ____

MOTHER FATHER

12. Name: Green Melton

13. Birthplace: Unknown (City, town, or county) Missouri (State or foreign country)

14. Maiden name: Alice Sudenia

15. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant: Mrs. MTH. Nesmith

(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 11th 1943 (Month) (Day) (Year)

(c) Place: burial or cremation: Hazelwood

18. (a) Signature of funeral director: H.H. Lohmeyer

(b) Address: Springfield, Mo.

19. (a) 2-11-43 (Date received local registrar) (b) Br Mr Handley (Registrar's signature)

987

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Feb. day: 9 year: 1943 hour: 10 minute: a. M.

21. I hereby certify that I attended the deceased from January 9, 1943, to Feby 8th, 1943 and that I last saw he alive on Feby 8th, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Paralysis Hemiplegia	40 days
Due to:	
Due to:	
Other conditions: Hypostatic Pneumonia (Include pregnancy within 3 months of death)	8 days

Major findings:
Of operations: ____
Of autopsy: No

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? (Specify type of place)

While at work? (e) Means of injury: ____

23. Signature: William R. Beatie (M. D. or other)

Address: 530 Med. arts Bldg. Date signed: 2-7-43

Springfield Mo.

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 Walter E. Hamilton

Licensed Embalmer No. 3808

P. O. Address Springfield Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 635-1

Registration District No. ____ Primary Registration District No. 2600 Registrar's No. ____

SUPPLEMENTARY

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: Burge Hosp (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: mo (Specify whether years, months or days)
In this community: 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Green
(c) City or town: Springfield (If outside city or town limits, write "RURAL")
(d) Street No.: 105 W Harrison (If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Alice Kemmen
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: wid
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Dec (Month) 9 (Day) 1865 (Year)
8. AGE: Years 77 Months 3 Days ____ (If less than one day) ____ hr. ____ min.
9. Birthplace: Mo (City, town, or county) ____ (State or foreign country)
10. Usual occupation ____
11. Industry or business ____
MOTHER FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)
14. Maiden name ____
15. Birthplace ____ (City, town, or county) ____ (State or foreign country)
16. (a) Informant ____
(b) Address ____
17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____
18. (a) Signature of funeral director ____
(b) Address ____
19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 9 year 1943 hour 10:00 minute a.m. M.
21. I hereby certify that I attended the deceased from ____, 19____ to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Paralysis	
Due to:	
Due to: Bronchial	
Other conditions (Include pregnancy within 3 months of death): Hypostatic pneumonia	
Major findings: Of operations:	
Of autopsy: 101	

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature ____ (M. D. or other) ____
Address ____ Date signed ____