

FILED JUN 14 1945  
Registration District No. ....

Primary Registration District No. 2000

Registrar's No. 426

1. PLACE OF DEATH: GREENE  
 (a) County  
 (b) City or town: SPRINGFIELD #60  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 229-N-CLAY ST  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State: MO  
 (b) County: GREENE 39  
 (c) City or town: Campbell Sup #10  
 (If outside city or town limits, write "RURAL")  
 (d) Street No.: R.F.D. - 8-  
 (If rural, give location)  
 (e) Citizen of foreign country? (Yes or No) \_\_\_\_\_  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME: BEULAH B HEWITT  
 3. (b) If veteran, name war: None  
 3. (c) Social Security No.: None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month: May day: 24  
 year: 1943 hour: 11:45 minute: a M.

4. Sex: F  
 5. Color or race: NEGRO  
 6. (a) Single, widowed, married, divorced: MARRIED  
 (b) Name of husband or wife: CLIFFORD HEWITT  
 6. (c) Age of husband or wife if alive: 56 years  
 7. Birth date of deceased: NOV 17 1910  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 28 1943 to May 24 1943  
 that I last saw her alive on May 24 1943  
 and that death occurred on the date and hour stated above.

8. AGE: Years: 32 Months: 6 Days: 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Apoplexy  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

9. Birthplace: CHICAGO (City, town, or county) ILL (State or foreign country)

Other conditions (Include pregnancy within 3 months of death):  
 Duration \_\_\_\_\_

10. Usual occupation: HOUSEWIFE

Major findings: Of operations: g3a  
 Of autopsy: \_\_\_\_\_

MOTHER FATHER  
 11. Industry or business  
 12. Name: DAVID JACKSON  
 13. Birthplace: FT SMITH ARK (City, town, or county) (State or foreign country)  
 14. Maiden name: KATIE MORTON  
 15. Birthplace: SPRINGFIELD MO (City, town, or county) (State or foreign country)

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

16. (a) Informant: MRS GRACE HICKMAN  
 (b) Address: 229-N-CLAY ST  
 17. (a) BURLIAL (Burial, cremation, or removal)  
 (b) Date thereof: 5-28-43 (Month) (Day) (Year)

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?

18. (a) Signature of funeral director: H V SMITH  
 (b) Address: 702 N-JEFFERSON AVE  
 19. (a) 5-26-43 (Date received local registrar)  
 (b) WETLANDLY (Registrar's signature)

While at work? (Specify type of place)  
 23. Signature: James E. Stealy (M. D. or other)  
 Address: Springfield Mo Date signed: May 26 1943

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

39  
2  
6

**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 Herbert V Smith  
Licensed Embalmer No. 4286  
P. O. Address 702 - N. Jefferson

**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.