

S. No. 2
M-1-4-41
5-17-39
PI X2639

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

31587
State File No.
Registrar's No. 782

FILED OCT 7 1943
Registration District No. 128

Primary Registration District No. 2000

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

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution:
I765 W Thoman
(d) Length of stay: In hospital or institution 1
In this community 1 years, months or days

3. (a) PRINT FULL NAME Cecil Aurelia Standridge
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 Married
6. (b) Name of husband David O. Standridge
6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased Aug. 4 1900

8. AGE: Years 43 Months I Days I7
If less than one day hr. min.

9. Birthplace Lebanon Missouri

10. Usual occupation House Wife

11. Industry or business

MOTHER FATHER {
12. Name Fernando W. Snow
13. Birthplace UNK Missouri
14. Maiden name Artie DeVasure
15. Birthplace UNK Missouri

16. (a) Informant David Standridge
(b) Address I765 W Thoman, Spfld, Mo.

17. (a) Burial (b) Date thereof 9-22-43
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director J.W. Klingner
(b) Address Springfield Missouri

19. (a) 9-20-43 (b) J.W. Klingner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(d) Street No. I765 W Thoman
(e) Citizen of foreign country? (Yes or No) No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 21
year 1943 hour 9.00 minute P.M.

21. I hereby certify that I attended the deceased from Aug 9 1943 to Sept 22 1943
that I last saw her alive on Sept 20 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Enlargement of Liver
Caused not known
Due to Colitis chronic

Other conditions (Include pregnancy within 3 months of death) 12481

Major findings: Of operations 0
Of autopsy 0

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) 0
(b) Date of occurrence 0
(c) Where did injury occur? 0
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature Felice R. Webb (M. D. or other)
Address Springfield Mo. Date signed 9/24/43

Duration
2 mo
27 d
PHYSICIAN
Underline the cause to which death should be charged statistically.

984 (Licensed Embalmer's Statement on Reverse Side)

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.....

Ogl. Slone Jr.

Licensed Embalmer No.....

4176

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, fact should be so stated above.

X