

REC'D JAN 11 1944
128

Registrar's No. 1068

Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH: **GREENE**

(a) County GREENE

(b) City or town SPRINGFIELD MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
MARY E WILSON HOME
(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 SPRINGFIELD
(If outside city or town limits, write "RURAL")

(d) Street No. 924 N. MAIN
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME CORA LOUISE WEST

3. (b) If veteran, name war NONE

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 26
year 1943 hour 5 minute 00 A.M.

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife None

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

7. Birth date of deceased FEB. 18 1874
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1940
19... to 12/26/43, 19...
that I last saw her alive on 12/25/43, 19...
and that death occurred on the date and hour stated above.

8. AGE: Years 69 Months 10 Days 8
If less than one day hr. min.

Immediate cause of death Cholecystitis

Duration 3 yrs.

9. Birthplace CLINTON CO IND. 1
(City, town, or county) (State or foreign country)

Due to.....

Due to.....

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

10. Usual occupation In home

Major findings:
Of operations.....

Of autopsy.....

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PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business.....

12. Name SAMUEL WEST

13. Birthplace unk. UNKNOWN
(City, town or county) (State or foreign country)

14. Maiden name ZERELDA ANN CARROLL

15. Birthplace unk. MILH. 1
(City, town, or county) (State or foreign country)

16. (a) Informant CORA L. WEST

(b) Address SPRINGFIELD MO.

17. (a) Burial (b) Date thereof DEC. 27-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation maple Park Cem

18. (a) Signature of funeral director J. W. Hines & Co.

(b) Address SPRINGFIELD MO.

19. (a) 12-27-43 (b) Dr. W. S. Hurdley
(Date received local registrar) (Registrar's signature)

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 J. D. Lemmon (M. D. or other) M.D.
Address Spfld. Mo. Date signed 12/27/43

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..... *Ogden Stone Jr.*
Licensed Embalmer No. *4126*
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.