

2  
41  
39  
29484

FILED JAN 25 1944  
Registration District No. 124

Primary Registration District No. 2000

Registrar's No. 5

1. PLACE OF DEATH:

(a) County GREENE  
Springfield Mo  
(b) City or town. (If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
924 W. Main 1  
(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 2  
(If outside city or town limits, write "RURAL") 6  
(d) Street No. 924 W. Main  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 0  
If yes, name country.

3. (a) PRINT FULL NAME ELLEN R. CAIRNS  
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. unk. 6. (c) Age of husband or wife if alive. unk. years  
7. Birth date of deceased. Oct 22 1858  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
85 2 10 hr. min.

9. Birthplace Waterloo Wis 1  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business.

MOTHER FATHER { 12. Name ROBERT CHALMERS 4  
13. Birthplace unk. Scotland  
(City, town, or county) (State or foreign country)  
14. Maiden name unk.  
15. Birthplace unk. 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Robert C. Cairns  
(b) Address 926 Lehigh St. Spfld. Mo.

17. (a) Burial (b) Date thereof 1-4 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Hayward

18. (a) Signature of funeral director J. W. Almgren etc  
(b) Address Springfield Mo

19. (a) 1-4-44 (b) S. W. 2 Hayward  
(Date received local register) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2  
year 1944 hour 12 minute None M.  
21. I hereby certify that I attended the deceased from 12/10/1943 to 1-2-1944  
that I last saw her alive on 1-2-1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-Neuritic disease 1 year  
Duration

Due to.....  
Due to.....  
Other conditions Influenza  
(Include pregnancy within 9 months of death)

Major findings: 131a  
Of operations.....  
Of autopsy.....

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?

While at work? (Specify type of place) (e) Means of injury 0

23. Signature C. E. Feller (M. D. or other)  
Address Springfield Mo Date signed 1-4-44

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 *Roy A. Swain*  
Licensed Embalmer No. *1763*  
P. O. Address *Springfield MO*

**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.**