

Registration District No. 128

Primary Registration District No. 5466

Registrar's No. 599

1. PLACE OF DEATH:

(a) County Greene

(b) City or town rural - S. Campbell Twp.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Route # 7.  
(If not in hospital or institution, write street number or location)

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

In this community 5 yr.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene

(c) City or town rural, S. Campbell Twp.  
(If outside city or town limits, write "RURAL")

(d) Street No. Route 7 - Springfield  
(If rural, give location)

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

3. (a) PRINT FULL NAME Deey Lourena Wilson

3. (b) If veteran, name war None

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17<sup>th</sup>  
year 1944 hour 9 minute 15 P.M.

4. Sex Female 5. Color or race white

6. (a) (b) Name of husband or wife unk. 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased Sept. 5 - 1857  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7, 10, 44 19, to 7, 17, 44 19;  
that I last saw OR alive on 7, 16, 44 19;  
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage, cerebral Duration 7 days

8. AGE: Years 86 Months 10 Days 12 If less than one day hr. min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions had stroke 8 yrs. ago, been bedfast last 4 yrs.  
(Include pregnancy within 3 months of death)

9. Birthplace unk. Mo.  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: 83 a 1

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

12. Name Jim Halderby

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

14. Maiden name unknown

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

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? \_\_\_\_\_

16. (a) Informant Mrs. Sol Maples

(b) Address Springfield, Mo. - # 7

23. Signature J. J. Musick, M.D. (M. D. or other) \_\_\_\_\_

Address Springfield, Mo. Date signed 7, 18, 44

17. (a) Burial (b) Date thereof July - 19 - 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Ridge

18. (a) Signature of funeral director J. W. Maples

(b) Address Clever, Mo.

19. (a) 7-18-44 (b) 5 W. E. Handley  
(Date received local registrar) (Registrar's signature)

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

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**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..... *J.W. Maples* .....

Licensed Embalmer No. *2985* .....

P. O. Address..... *Clener 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.**

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