

No. 2
-1-4-41
5-17-39
X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. Vail
State File No. 23952
Registrar's No. 68952

FILED SEP 9 1944
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: Sppl. Baptist Hosp.
(d) Length of stay: In hospital or institution 10 Weeks
In this community 10 Weeks

2. USUAL RESIDENCE OF DECEASED: Laclede 53
(a) State Missouri (b) County Bollinger
(c) City or town Rural Conway, Mo.
(e) Citizen of foreign country? (Yes or No) 1

3. (a) PRINT FULL NAME Maude Ichor
3. (b) If veteran, name war No
3. (c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug. day 23
year 1944 hour 12 minute noon M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife UNK!
6. (c) Age of husband or wife if alive Dec. 27, 1885

21. I hereby certify that I attended the deceased from June 17 to Aug 23, 1944
that I last saw her alive on Aug 23, 1944
and that death occurred on the date and hour stated above.

7. Birth date of deceased: Sept. 27, 1885
8. AGE: Years 58 Months 10 Days 26

Immediate cause of death: Cirrhosis of Liver
Due to: 2 yrs

9. Birthplace: Dallas County Missouri
10. Usual occupation: Home

Other conditions: 124 fl
Major findings: 124 fl

MOTHER FATHER { 11. Industry or business:
12. Name John Ichor
13. Birthplace Unknown Missouri
14. Maiden name Susan Forkner
15. Birthplace Laclede County Missouri

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

16. (a) Informant Mrs. Fred Mathews
(b) Address Hempsted, New York
17. (a) Removal (b) Date thereof 8/24/44

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(c) Place: burial or cremation Conway, Mo.
18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.
19. (a) 8-23-44 (b) S. W. Handley

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature Dr. Vail (M.D. or other) MS
Address Springfield Mo Date signed 8/23/44

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 Walter E. Hamelin

Licensed Embalmer No. 3808

P. O. Address Brunswick, Me.

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.