

1. PLACE OF DEATH:

GREENE

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
444 Nichols
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 444 Nichols
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 9th
year 1944 hour 5 minute 15 A.M.

21. I hereby certify that I attended the deceased from 6-11 1943 to 9-9 1944
that I last saw her alive on SEPT. 7 1944
and that death occurred on the date and hour stated above.

Immediate cause of death
TRANSITION
DEHYDRATION
Duration 1 wk

Due to

Due to

Other conditions: SENILE DETERIOR 2 YRS
(Include pregnancy within preceding year)
ATION.

Major findings:
Of operations 162a
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) None
(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?
(Specify type of place) (e) Means of injury 0
Signature [Signature] (M. D. or other) M.D.
Address 200 1/2 1st St, Bldg. Date signed 9-9-44

3. (a) PRINT FULL NAME SALLIE ANDREWS
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 Married
6. (b) Name of husband or wife John R. Andrews 6. (c) Age of husband or wife if alive 64 1/2 years
7. Birth date of deceased March 1, 1881
(Month) (Day) (Year)

8. AGE: Years 63 Months 6 Days 8 hr. .. min. ..

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

10. Usual occupation Housewife

11. Industry or business

12. Name St. Campbell
13. Birthplace unk. unk.
(City, town, or county) (State or foreign country)
14. Maiden name unk.
15. Birthplace unk. unk.
(City, town, or county) (State or foreign country)

16. (a) Informant John R. Andrews
(b) Address 444 Nichols St. Bldg.

17. (a) Burial (b) Date thereof 9-13-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Marshall

18. (a) Signature of funeral director Fred C. Shomo
(b) Address 1100 Boonville Ave
19. (a) 9-11-44 (b) [Signature]
(Date received local registrar) (Registrar's signature)

944 (Licensed Embalmer's Statement on Reverse Side) Springfield, Mo.

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

MOTHER FATHER

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..... *Fred C. Phewes*
Licensed Embalmer No. *2899*
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.

X