No. 2
-41
-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34250

FILED OCT 24 1944

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 801

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

39
2
6

1. PLACE OF DEATH:

(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: City Hospital
(If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community two weeks
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield 2
(If outside city or town limits, write "RURAL") 6

(d) Street No. 436 E. Harrison St
(If rural, give location)

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

3. (a) PRINT FULL NAME Nabbie Kelley

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 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 Oct (Month) 15 (Day) 1879 (Year)

8. AGE:	Years	Months	Days	If less than one day
	64	11	20	hr. min.

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

10. Usual occupation Clerk Towsend Plan

11. Industry or business Towsend Plan

FATHER
12. Name Unk
13. Birthplace Unk (City, town, or county) Unk (State or foreign country)

MOTHER
14. Maiden name Unk
15. Birthplace Unk (City, town, or county) Unk (State or foreign country)

16. (a) Informant Mrs Dickson
(b) Address Spfd, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 8, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director Fred C. Thieme
(b) Address 1100 Boonville St., Spfd, Mo

19. (a) 10-6-44 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 5th
year 1944 hour 4 minute 55 P.M.

21. I hereby certify that I attended the deceased from 9/21/44, 19..., to 10/4, 1944
that I last saw her alive on 10/4/44, 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Nephritis	
Due to	
Due to	
Other conditions Secondary High B.P. (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature A. E. Alsop (M. D. or other)
Address Springfield, Mo Date signed 10/6/44

984

(Licensed Embalmer's Statement on Reverse Side)

JAN 28 1947

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. Thieme

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1 0 4

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 80

1. PLACE OF DEATH:

(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
(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 (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Nabbie Kelley

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct (Month) 15 (Day) 1879 (Year)

8. AGE: Years 64 Months 11 Days 28 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 5
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis Chronic

Due to

Due to 131 b

Other conditions Secondary High B.P.
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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

23. Signature A E Adder (M. D. or other)

Address Date signed

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

24250