

FILED DEC 27 1944  
128

Registration District No. ....

Primary Registration District No. **2000**

Registrar's No. **900**

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

**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 **710 S. NEWTON**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **3 yr.**  
(Specify whether 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. **710 S. NEWTON AVE.**  
(If rural, give location)  
 (e) Citizen of foreign country? **NO.** (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **ADDA CHARLOTTE STONE**

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **DEC** day **9<sup>th</sup>**  
 year **1944** hour **5** minute **35 P. M.**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

**21. I hereby certify that I attended the deceased from** **Jan 12, 1944** to **Dec 9, 1944**  
 that I last saw her alive on **Dec 9, 1944**  
 and that death occurred on the date and hour stated above.

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, divorced, **WIDOW**  
 6. (b) Name of husband or wife **UNKN.** 6. (c) Age of husband or wife if alive **Dec 18 66**  
 7. Birth date of deceased **MARCH 5, 1866**  
(Month) (Day) (Year)

**Immediate cause of death**  
**Died suddenly from heart attack**  
 Due to **she had been in very poor health for two years**  
 Due to \_\_\_\_\_

**8. AGE:** Years **78** Months **9** Days **4** If less than one day \_\_\_\_\_  
hr. min.

Other conditions **Age**  
(Include pregnancy within 3 months of death)

9. Birthplace **UNKN. SWEDEN**  
(City, town, or county) (State or foreign country)

Major findings: Of operations **None** Of autopsy **No**

10. Usual occupation **HOUSE WIFE**  
 11. Industry or business **AT HOME**  
 12. Name **MAGNUS LARSON**  
 13. Birthplace **UNKN. SWEDEN**  
(City, town, or county) (State or foreign country)  
 14. Maiden name **MARIE OBERG**  
 15. Birthplace **UNKN. SWEDEN**  
(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) **No**  
 (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 **Augh V. Stone**  
 (b) Address **710 S. Newton, Springfield, Mo.**  
 17. (a) **Burial** (b) Date thereof **Dec. 12-1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Humansville Mo. Cem**  
 18. (a) Signature of funeral director **J. W. Klingner**  
 (b) Address **Springfield, Mo.**  
 19. (a) **12-11-44** (b) **J. M. Sawyer**  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_  
(Specify type of place) (2) Means of injury  
 23. Signature **Robert Williams** (M. D. or other) \_\_\_\_\_  
 Address **Springfield Mo** Date signed **12-11-44**

FEB 8 1945

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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 Ogle Stone Jr.  
Licensed Embalmer No. 4776  
P. O. Address Springfield

**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