

FILED JAN 10 1945
128

Registration District No.

Primary Registration District No. 2000

Registrar's No. 975

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 Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 hours (Specify whether years, months or days)

3. (a) PRINT FULL NAME Novie Belle Wilson

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

4. Sex Female 5. Color or race White 6. (a) Single, married, divorced, Widowed

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased September 5, 1872
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>72</u>	<u>3</u>	<u>26</u> hr. min.

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

10. Usual occupation In Home

11. Industry or business

MOTHER FATHER { 12. Name UNK Hobson
13. Birthplace UNK UNK
(City, town, or county) (State or foreign country)
14. Maiden name Addie UNK
15. Birthplace UNK UNK
(City, town, or county) (State or foreign country)

16. (a) Informant W. H. Wilson
(b) Address Springfield, Missouri

17. (a) ~~BURIAL~~ Removal (b) Date thereof Jan. 1, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mayfield, Kentucky

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
(b) Address Springfield, Missouri

19. (a) 1-2-45 (b) W. H. Wilson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield,
(If outside city or town limits, write "RURAL")
(d) Street No. 1650 E. Grand
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 31,
year 1944 hour 11:30 minute A. M.

21. I hereby certify that I attended the deceased from 12-26
1944 to 12-31 1944
that I last saw him alive on 12-31 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Duration 5 days

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 107

Major findings: Of operations
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?

While at work? (Specify type of place) (e) Means of injury 0

23. Signature C. J. Feller (M. D.)
Address Springfield, Mo. Date signed 1-2-45

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

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 Lewis S. Scharf
Licensed Embalmer No. 3802
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.