

FILED JAN 25 1945

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

Registrar's No. 25

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:  
2515 N. National  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None  
In this community 2 months  
years, months or days

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. 2515 N. National  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Georgie A. Prewitt

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 Widowed

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

7. Birth date of deceased October 29, 1864  
(Month) (Day) (Year)

8. AGE: Years 80 Months 2 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Pike County, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation In Home

11. Industry or business \_\_\_\_\_

12. Name Unknown

13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Jane Walter

(b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof 1/12/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salem, Missouri

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 1-11-45 (b) D. W. Handley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 10,  
year 1945 hour 1:15 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from Nov. 22, 1944 to Jan 10, 1945  
that I last saw her alive on Jan 9, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute cholecystitis with obstruction Duration 2 weeks

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions: Chs hypertensive Cardia  
(Include pregnancy within 3 months of death) vascular dis with decompression

Major findings: \_\_\_\_\_  
Of operations: 93d  
Of autopsy: \_\_\_\_\_

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) \_\_\_\_\_  
(Specify means of injury) \_\_\_\_\_

23. Signature Arthur P. Knapp (M: D. or other) MD  
Address 410 E. 10th Date signed Jan 11, 1945

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

2873

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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