

FILED MAR 12 1945
Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 142

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:
St. John's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 DAYS (Specify whether years, months or days)

3. (a) PRINT FULL NAME MARILYN KAY HARPER

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 FEB. 12 1945
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 8 If less than one day hr. min.

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

10. Usual occupation Infant

11. Industry or business at home

12. Name Charles Ross Harper

13. Birthplace Kansas City Mo. A
(City, town, or county) (State or foreign country)

14. Maiden name Dorline Zepha Dodson

15. Birthplace Greene Co. Mo. O
(City, town, or county) (State or foreign country)

16. (a) Informant Charles Ross Harper
 (b) Address Springfield Mo.

17. (a) Burial Date thereof Feb 21 - 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Our Project Cem.

18. (a) Signature of funeral director J. L. Johnston
 (b) Address Springfield Mo.

19. (a) 2-20-45 (b) Dr. W. H. Haulley
(Date received local registrar) (Registrar's signature)

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. 2043 N. ROGERS
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? ✓ A years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 20 year 1945 hour 10 minute 38 am. M.

21. I hereby certify that I attended the deceased from Feb 12, 1945, to Feb 20, 1945, that I last saw her alive on Feb 20, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Heart Disease

Due to _____

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations no

Of autopsy no

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 _____

23. Signature J. L. Johnston (M. D. or other) MD
 Address Springfield Mo Date signed 2/20/45

Duration 8 days
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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

9
2
6

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 Ray A. Loucks
Licensed Embalmer No. 1763
P. O. Address Springfield and

-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