

FILED APR 9 1945
128

Registration District No.

Primary Registration District No. 5456

Registrar's No. 7

1. PLACE OF DEATH: GREENE

(a) County GREENE

(b) City or town SPRINGFIELD

(c) Name of hospital or institution: R.F.D. # 8

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 35 yr. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County GREENE

(c) City or town R.F.D. # 8 SPRINGFIELD

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

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

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

If yes, name country

3. (a) PRINT FULL NAME JESSIE DELK

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 MARRIED

6. (b) Name of husband or wife ROBERT DELK

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased JULY 7 1887

8. AGE: Years 57 Months 8 Days 15 If less than one day hr. min.

9. Birthplace WRIGHT CO. MO. (City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business AT HOME

12. Name JOHN FORREST

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

14. Maiden name JULIA

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

16. (a) Informant Robert Delk

(b) Address R.F.D. # 8, Springfield Mo.

17. (a) Burial (b) Date thereof Mar 23 1945

(c) Place: burial or cremation Maple Park Cem

18. (a) Signature of funeral director W. Klingner

(b) Address Springfield Mo.

19. (a) Mar 23 1945 (b) Florence Britain (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 22 year 1945 hour 4 minute 10 P. M.

21. I hereby certify that I attended the deceased from Dec. 4, 1944, to 3/22/45, 19...; that I last saw h..... alive on....., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration Few min.

Due to

Due to

Other conditions Partial hemoplegia 1 yr (Include pregnancy within 3 months of death)

Major findings: Of operations: 83001 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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place)

23. Signature J. D. Lemmon (M. D. or other) M.D.

Address Springfield, Mo. Date signed 3/23/45

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

MOTHER FATHER

1241

RECEIVED

Greene County Health Office,

County File Number 45-4-32

Date Filed 4-7-45

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 Roy C. Clavin

Licensed Embalmer No. 1763

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.