

FILED APR 9 1945  
Registration District No. 128

Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County GREENE  
Springfield

(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 6 days (Specify whether  
In this community 33 years years, months or days)

3. (a) PRINT FULL NAME Lora Elmira Stewart

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife James Hershey Stewart

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

7. Birth date of deceased December 6, 1891  
(Month) (Day) (Year)

8. AGE: Years 53 Months 3 Days 15  
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business In Home

MOTHER FATHER { 12. Name Sam Arnold

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

14. Maiden name Eliza Patterson

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

16. (a) Informant James H. Stewart

(b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof March 23 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood Cemetery

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

(b) Address Springfield, Missouri

19. (a) 3-21-45 (b) H. W. H. H. H.  
(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. 1318 Roanoke  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19th,  
year 1945 hour 5:30 minute A. M.

21. I hereby certify that I attended the deceased from  
Jan 20 1945 to March 19 1945  
that I last saw her alive on March 19 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Leukemia

Duration 576

Due to 742

Due to

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

Major findings:  
Of operations

Of autopsy None

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) No

(b) Date of occurrence

(c) Where did injury occur? No  
(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)  
While at work? No (Specify type of place)  
(e) Means of injury No

23. Signature Robert Williams (M. D. or other)  
Address Springfield, Mo. Date signed 3-20-45

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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.....

*Lewis G Schupp*

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.**

X