

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 25 1945
128

Registration District No.

Primary Registration District No. **2000**

Registrar's No. **301**

1. PLACE OF DEATH:

(a) County..... **GREENE**
Springfield

(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Burge Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **23 Days** Specify whether

In this community **Int. travels for 4 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Carrone**

(c) City or town **Springfield**
(If outside city or town limits, write "RURAL")

(d) Street No. **1068 South New**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Lydia Belle Quinn**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **UNK**

4. Sex **female** 5. Color or race **white**

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

6. (b) Name of husband or wife **Robert W. Quinn**

6. (c) Age of husband or wife if alive **73** years

7. Birth date of deceased **June 2, 1877**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
67	10	7	hr. min.

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

10. Usual occupation **Homemaker**

11. Industry or business

MOTHER FATHER

12. Name **James M. Bonar**

13. Birthplace **UNK. Kentucky**
(City, town, or county) (State or foreign country)

14. Maiden name **Cassandra Russell**

15. Birthplace **UNK. Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ruth E. Quinn**

(b) Address **1068 South New, Spfld, Mo**

17. (a) **Rural** (b) Date thereof **4/10/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Park**

18. (a) Signature of funeral director **H.H. Lohmeyer**

(b) Address **Springfield, Mo.**

19. (a) **4-10-45** (b) **W. W. Hardley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **9**
year **1945** hour **8** minute **40** A.M.

21. I hereby certify that I attended the deceased from **March 18**, 19**45**, to **April 9**, 19**45**;
that I last saw her alive on **April 8**, 19**45**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Accident**

Duration **23 days**

Due to

Due to

Other conditions **Chronic hypertrophic arthritis**
(Include pregnancy within 3 months of death)

PHYSICIAN **3 yrs**

Major findings:
Of operations **(8 30)**

Of autopsy

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?

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

While at work? (Specify type of place)

(a) Means of injury

23. Signature **Thomson H. Hines** (M. D. or other) **MD**
Address **Springfield, Mo.** Date signed **4/9/45**

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

JUN 22 1945

MAR 22 1946

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 Walter E Hamella

Licensed Embalmer No. 3808

P. O. Address Burgess 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.