

FILED APR 25 1945
Registration District No. **2000**

Primary Registration District No. **2000**

Registrar's No. **278**

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: **Burge Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days**
(Specify whether 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. **2011 N. Elizabeth**
(If rural, give location)
(e) Citizen of foreign country? **(1) (Yes or No)**
If yes, name country _____

3. (a) PRINT FULL NAME **Mrs. Goldie Morelock**

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

7. Birth date of deceased **Aug. 28, 1896**
(Month) (Day) (Year)

8. AGE: Years **48** Months **6** Days **5** If less than one day hr. min.

9. Birthplace **Douglas Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **N.W.**

11. Industry or business _____

12. Name **Will Clark**

13. Birthplace **Douglas Co. Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Maude Helmerson**

15. Birthplace **Douglas Co. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Jess Horn (sister)**
(b) Address **3027 E. 31st K.C., Mo.**

17. (a) **Burial** (b) Date thereof **4-5-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Alma Johnson**
(b) Address **Springfield, Mo.**

19. (a) **4-7-45** (b) **B. W. Handley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **3**
year **1945** hour **2:00** minute **A. M.**

21. I hereby certify that I attended the deceased from **2/29/45**
1945 to **5/3/45** 1945

that I last saw him alive on **4/3/45** and that death occurred on the date and hour stated above.

Immediate cause of death **Meningitis** Duration **3 days**

Due to **pyocephalitis** 5. days

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **flw** Of autopsy _____

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) _____
(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 **O. E. Feller** (M. D. or other) _____

Address **Springfield, Mo.** Date signed **4/17/45**

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

MOTHER FATHER

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.....

L. C. Roof

Licensed Embalmer No.....

3044

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.

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