

FILED MAY 28 1945
128

Registration District No. _____

Primary Registration District No. 2000

Registrar's No. 373

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: Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days
In this community 60 Years
(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. 2131 East Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Amy Lee Breshears

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Walter Breshears 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased November 10, 1884
(Month) (Day) (Year)

8. AGE: Years 60 Months 5 Days 24 If less than one day hr. _____ min. _____

9. Birthplace Greene Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business In Home

12. Name William W. Putman

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

14. Maiden name Eliza Myers

15. Birthplace Salem N.C.
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Breshears

(b) Address 2131 N East Ave., Spfld., Mo

17. (a) Burial (b) Date thereof 5-7-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

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

(b) Address Springfield Mo.

19. (a) 5-7-45 (b) S. W. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4
year 1945 hour 11:57 minute _____ P. M.

21. I hereby certify that I attended the deceased from May 1, 1945 to May 4, 1945
that I last saw her alive on May 4, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction Duration 3 days

Due to Jayemia

Due to Suppression of urine 8 days

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

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 Ross Glyn (M. D. or other) MD

Address Springfield, Mo. Date signed 5/7/45

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 *May Rhodes*.....
Licensed Embalmer No. *4071*.....
P. O. Address *Springfield*.....

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.