

FILED JUN 11 1945
128

Registration District No. _____

Primary Registration District No. **2000**

Registrar's No. **408**

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:
1200 W. THOMAN
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **GREENE**
(c) City or town **SPRINGFIELD**
(If outside city or town limits, write "RURAL")
(d) Street No. **1200 W. THOMAN.**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (c) PRINT FULL NAME **MARY A. JEFFRIES**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color of race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOW**

6. (b) Name of husband or wife **UNK.** 6. (c) Age of husband or wife if alive **Dec. 1865**

7. Birth date of deceased (Month) **Feb.** (Day) **22** (Year) **1865**

8. AGE: Years **80** Months **2** Days **22** If less than one day hr. _____ min. _____

9. Birthplace (City, town, or county) **UNK.** (State or foreign country) **OHIO**

10. Usual occupation **HOUSE WIFE**

11. Industry or business **AT HOME**

12. Name **NATHAN G. HAGEN BOOK**

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

14. Maiden name **LAVINA PETRY**

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

16. (a) Informant **Charles Jeffries**

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

17. (a) **Burial** (b) Date thereof (Month) (Day) (Year) **May 20 - 1945**

(c) Place: burial or cremation **Green Lawn Cem**

18. (a) Signature of funeral director **J. W. Kingner & Co.**

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

19. (a) **5-19-45** (b) **S. M. Staudley** (Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **17** year **1945** hour **7** minute **00** P. M.

21. I hereby certify that I attended the deceased from **1-4** 19**40**, to **5-17** 19**45** that I last saw **her** alive on **5-16** 19**45** and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic nephritis** **3yr.**
Due to **Chronic heart lesion**

Due to **Hypertension**

Other conditions **UNK.** (Include pregnancy within 3 months of death)

Major findings: Of operations **none** Of autopsy **none**

Duration

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? **UNK.** (City or town) (County) (State)

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

While at work? **UNK.** (Specify type of place) (e) Means of injury **UNK.**

23. Signature **J. F. Freeman** (M. D. or other) _____

Address **Springfield** Date signed **5/18/45**

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

OCT 21 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.....

Max Rhodes

Licensed Embalmer No.....

407

P. O. Address.....

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