S. No. 2
M—2-43
5-17-39
X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr. Feller 27385

State File No.

FILED SEP 12 1945

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 666

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: 719 S. Fremont (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) 31 Years

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene 39

(c) City or town: Springfield (If outside city or town limits, write "RURAL") 2

(d) Street No.: 719 S. Fremont (If rural, give location) 6

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME: Margaret F. Jairett

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Female 1

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married 1

6. (b) Name of husband or wife: Harry D. Jairett

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

7. Birth date of deceased: May (Month) 1, (Day) 1892 (Year)

8. AGE: Years	Months	Days	If less than one day
53	3	22	hr. min.

9. Birthplace: Kiasheim (City, town, or county) Germany 11 (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Adolph Luz

13. Birthplace: UNK. (City, town, or county) Germany 4 (State or foreign country)

MOTHER

14. Maiden name: Wilhelmie Freund

15. Birthplace: UNK (City, town, or county) Germany 4 (State or foreign country)

16. (a) Informant: Harry D. Jairett

(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/45 (Month) (Day) (Year)

(c) Place: burial or cremation: Greenlawn

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

(b) Address: Springfield, Mo.

19. (a) 8-25-45 (Date received local registrar) (b) by W.G. Hundley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 23 year 1945 hour 12 noon minute M.

21. I hereby certify that I attended the deceased from 2-12, 1945, to 8/23/, 1945, that I last saw him alive on 8-23, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Occlusion of Common bile duct following Cholecystectomy

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Underline the cause to which death should be assigned 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: C. E. Feller (M. D. or other)

Address: Springfield Mo. Date signed 8/23/

984 (Licensed Embalmer's Statement on Reverse Side)

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. Hamilla

Licensed Embalmer No. 3808

P. O. Address Springfield Me

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.