S. No. 2
M—8-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 12 1945

State File No. 27398

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 661

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 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Christian 22
(c) City or town rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. Ozark, R#1 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME Connie Sue Mabe
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex female 1
5. Color or race white
6. (a) Single, widowed, married, divorced single 1
6. (b) Name of husband or wife None
6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased Nov. 12, 1944 (Month) (Day) (Year)
8. AGE: Years 0 Months 9 Days 9 If less than one day hr. min.
9. Birthplace Christian Co. (City, town, or county) Mo. 1 (State or foreign country)
10. Usual occupation Infant
11. Industry or business
MOTHER FATHER
12. Name Donald Mabe
13. Birthplace Unk. (City, town, or county) Mo. (State or foreign country) 1
14. Maiden name Hazel Warren
15. Birthplace Unk. (City, town, or county) Mo. 0 (State or foreign country)
16. (a) Informant Mr. Donald Mabe
(b) Address Ozark, Mo. R#1
17. (a) burial (Burial, cremation, or removal) (b) Date thereof Aug. 22, 45 (Month) (Day) (Year)
(c) Place: burial or cremation Highlandville, cem.
18. (a) Signature of funeral director T. W. Maples
(b) Address Clever, Mo.
19. (a) 8-23-45 (Date received local registrar) (b) W. S. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 21 year 1945 hour 8:00 minute A. M.
21. I hereby certify that I attended the deceased from August 18, 1945, to August 21, 1945 that I last saw her alive on August 21, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	1 wk.
Due to Congenital malformation of the heart	life
Due to	
Other conditions Mongolism (Include pregnancy within 3 months of death)	life

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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature Thomas S. Hunt (M. D. or other) MD
Address Medical Arts Building Date signed 8/23/45
Springfield, Mo.

(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 J.W. Maples

Licensed Embalmer No. 2985

P. O. Address Clever, 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.