

FILED SEP 12 1945

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 681

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 _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County GREENE 39
(c) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL")
(d) Street No. 1846 E. Atlantic
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME KATE SWITZER.

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 Widow

6. (b) Name of husband or wife UNK. 6. (c) Age of husband or wife if alive Dec. years 1868

7. Birth date of deceased July 2, (Month) (Day) (Year)

8. AGE: Years 77 Months 1 Days 26 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business at Home

12. Name James Wright

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

14. Maiden name UNK. Craft

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

16. (a) Informant Mrs. Nellie McMahon

(b) Address SPRINGFIELD MO.

17. (a) Burial (b) Date thereof 8-30-45 (Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director J. W. Kingner & Co (b) Address SPRINGFIELD MO.

19. (a) 8-28-45 (b) W. H. Hardley (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Aug. day 28 year 1945 hour 3 minute 45 A.M.

21. I hereby certify that I attended the deceased from 8/15 to 8/28 that I last saw him alive on 8/27 and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction Duration _____

Due to Abdominal tumor (possible) malignant

Due to _____ Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations no Of autopsy no

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 D. F. Frensch (M. D. or other) Address Springfield Date signed 8/29/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

9
2
6

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 G. Rhodes
407
Springfield

Licensed Embalmer No.

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.