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ev. 5-17-39
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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 OCT 8 1945

State File No. 30536

Registration District No. 28 Primary Registration District No. 2000 Registrar's No. 760

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: 815 Copeland (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: None (Specify whether years, months or days)
In this community:

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Greene 39
(c) City or town: Springfield 2 (If outside city or town limits, write "RURAL")
(d) Street No.: 815 Copeland 6 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country:

3. (a) PRINT FULL NAME: Lucy ~~Frances~~ Burns
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: Married
6. (b) Name of husband or wife: Mr. Waller Burns
6. (c) Age of husband or wife if alive: Unk. years
7. Birth date of deceased: February (Month) 17, (Day) 1874 (Year)

8. AGE: Years	Months	Days	If less than one day
71	7	17	hr. min.

9. Birthplace: Macon County, (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Marceline Sivadon
13. Birthplace: ~~France~~ Unk. (City, town, or county) France (State or foreign country)
MOTHER 14. Maiden name: Mary Cline
15. Birthplace: ~~Missouri~~ Unk. (City, town, or county) Mo. (State or foreign country)
16. (a) Informant: Mr. Waller Burns
(b) Address: 815 Copeland - Spfd., Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 28, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: East Lawn Cemetery
18. (a) Signature of funeral director: Alma Lohmeyer Funeral H.
(b) Address: 534 St. Louis Street, Spfd, Mo
19. (a) 9-28-45 (Date received local registrar) (b) W E Hardy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 24 year 1945 hour 8 minute 00 P.M.
21. I hereby certify that I attended the deceased from Oct 15, 1944, to Sept 24, 1945 that I last saw her alive on Sept 24, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocardial insufficiency	1 yr
Due to: Rheumatic heart disease	1 yr
Due to: Chronic cardio-vascular disease	yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death): Mitral regurgitation	yrs

Major findings:
Of operations:
Of autopsy: 93d

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:
23. Signature: Arthur Smith M.D. (M. D. or other)
Address: 450 E. Cowell St. Spfd., Mo. Date signed:

984

(Licensed Embalmer's Statement on Reverse Side)

OCT 10 1945

OCT 22 1945

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 Lewis G. Scharff

Licensed Embalmer No. 3802

P. O. Address Springfield, 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.