S. No. 2
DM—2-43
v. 5-17-39
I X35697

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. Burke

State File No. 33730

FILED NOV 13 1945

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 832

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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: SPFD. Baptist Hosp. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 4 Hours (Specify whether years, months or days)
In this community: 4 Hours

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.: 1122 Pythian 1
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Infant Daughter of Mr. Mrs. Horace Faught
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: 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: Oct. (Month) 16 (Day) 1945 (Year)

8. AGE: Years	Months	Days	If less than one day
0	0	0	4 hr. min.

9. Birthplace: Springfield (City, town, or county) Missouri 0 (State or foreign country)
10. Usual occupation: Infant
11. Industry or business:
FATHER 12. Name: Horace Faught
FATHER 13. Birthplace: Nixa (City, town, or county) Missouri 0 (State or foreign country)
MOTHER 14. Maiden name: Susie Hines
MOTHER 15. Birthplace: Woodson County (City, town, or county) Kansas 1 (State or foreign country)
16. (a) Informant: Horace Faught
(b) Address: Springfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/17/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Payne Cemetery
18. (a) Signature of funeral director: H.H. Lohmeyer
(b) Address: Springfield, Mo.
19. (a) 10-19-45 (Date received local registrar) (b) W.E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 16 year 1945 hour 6 minute 45p. M.
21. I hereby certify that I attended the deceased from October 16, 1945, to October 16, 1945 that I last saw h. er alive on October 16, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Premature Birth	Duration
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

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

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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: Walter H. Burke (M. D. or other)
Address: 410 Woodruff Bldg. Date signed 10-19-45

984 (Licensed Embalmer's Statement on Reverse Side) Spfd., Mo.

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.....

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. This body not embalm
H H Johns turner Hon