S. No. 2
M—2-43
. 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

FILED OCT 27 1945

33775

State File No. .....

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 798

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: 618 S. KANSAS AVE. 1
(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 2
(If outside city or town limits, write "RURAL")

(d) Street No. 618 S. KANSAS AVE. 6
(If rural, give location)

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

If yes, name country ✓

3. (a) PRINT FULL NAME LUCY JANE MEADOR

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

7. Birth date of deceased JULY (Month) 27 (Day) 1864 (Year)

8. AGE: Years 81 Months 2 Days 10 If less than one day ..... hr. ..... min.

9. Birthplace POLK CO. (City, town, or county) MO. (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name BENJAMIN RUPARD.
13. Birthplace UNK. (City, town, or county) UNKNOWN (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace UNK. (City, town, or county) UNKNOWN (State or foreign country)

16. (a) Informant Ora Meador
(b) Address SPRINGFIELD MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Hopewell Cem.

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

19. (a) 10-9-45 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 7 year 1945 hour 3 minute 00 A. M.

21. I hereby certify that I attended the deceased from 9-26, 1945 to 10-7-, 1945 that I last saw her alive on 10-6-, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute nephritis	
Due to Attack of Flu.	
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.

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 W Kelly (M. D. or other)

Address Springfield, Mo. Date signed 10-8-45

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 Roy Albaum

Licensed Embalmer No. 1763

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.