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

Dr. Lowe 33800 ✓

State File No.

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 808

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: St. John's Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Days (Specify whether

In this community 54 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 37

(c) City or town Springfield 2 (If outside city or town limits, write "RURAL")

(d) Street No. 730 E. Walnut 6 (If rural, give location)

(e) Citizen of foreign country? 6 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mary Lyons Scofield

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Lloyd Scofield

6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased Aug. (Month) 29 (Day) 1891 (Year)

8. AGE: Years 54 Months 1 Days 10 If less than one day hr. min.

9. Birthplace Springfield (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Home

11. Industry or business

FATHER
12. Name Robert Lyons
13. Birthplace UNK (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Sallie Owen
15. Birthplace Owensville (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Joe Lyons

(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/45 (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 10-11-45 (Date received local registrar) (b) Dr. W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 9 year 1945 hour 4:00 minute a. M.

21. I hereby certify that I attended the deceased from 1943, 19 to 10/8, 1945 that I last saw her alive on 10/8/45, 19 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer uterus

Due to Extension to stomach & liver

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 H A Lowe (M. D. or other)

Address Springfield, Mo. Date signed 10/9/45

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(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 Walter E Hamilton

Licensed Embalmer No. 3808

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.