

7. S. No. 2
OM-5-42
Rev. 5-17-39
X32873

Dr. Fitch
37179
State File No. _____
Registrar's No. 930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 28 1945
Registration District No. 128
Primary Registration District No. 2000

39
2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(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 3 Days
In this community 3 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 2342 N. Johnson
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Delia Cay
(b) If veteran, name war No
(c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 11
year 1945 hour 11:00 minute P. M.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Walter Cay
(c) Age of husband or wife if alive 46 yrs. years
7. Birth date of deceased March 12, 1880
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1945 to Nov 11 1945
that I last saw alive on Nov 11 1945
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
65 7 29 _____ hr. _____ min.

Immediate cause of death Arteriosclerosis of brain
Duration 29 yrs.

9. Birthplace Chattanooga Tennessee
(City, town, or county) (State or foreign country)

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

10. Usual occupation Housewife

Major findings: _____
Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name Jim Rose
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Mary Quinn
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

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

16. (a) Informant Walter Cay
(b) Address Springfield, Mo.

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? _____

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/45
(Month) (Day) (Year)
(c) Place: burial or cremation National Cem.

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature [Signature] (M. D. or other) MD
Address Springfield Mo Date signed 11-28-45

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.
19. (a) 11-14-45 (Date received local registrar) (b) [Signature] (Registrar's signature)

DEC 9 1948

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

Roy H. Mercer Jr., Registered Apprentice No. 380
working under my personal supervision.

Signed L. D. Roman

Licensed Embalmer No. 3177

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.

X