

S. No. 2
M-5-43
5-17-39
I X36871

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

37215

FILED NOV 28 1945

State File No. _____
Registrar's No. 910

Registration District No. 128 Primary Registration District No. 2000

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: Springfield Baptist Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Texas 107
(c) City or town Bucyrus 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS. OPAL HUTCHISON
3. (b) If veteran, name war None 3. (c) Social Security No. UNK.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month November day 6
year 1945 hour 1: minute 00 P. M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife William O. Hutchison
6. (c) Age of husband or wife if alive UNK. years
7. Birth date of deceased October UNK. 1912
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11-2, 1945 to 11-6, 1945
that I last saw her alive on 11-5, 1945
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
33 UNK. UNK. hr. min.

Immediate cause of death Septicemia
Pneumonia Duration 4 days

9. Birthplace Unknown UNK. 9
(City, town, or county) (State or foreign country)

Due to Deficient del. transverse
fracture and attempt at
reduction first in hospital then
Other conditions moved to hosp. complete
(include pregnancy within 6 months of death)

10. Usual occupation Housewife
11. Industry or business _____
12. Name Racher Tinker
13. Birthplace Unknown UNK. 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown UNK. 9
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy 1475
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant William O. Hutchison
(b) Address Bucyrus, Missouri
17. (a) Removal (b) Date thereof 11/6/1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bucyrus, Missouri
18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
(b) Address Springfield, Missouri
19. (a) 11-6-45 (b) BY MRS. Hutchison
(Date received local registrar) (Registrar's signature)

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 0
23. Signature C. E. Feller (M. D. or other)
Address Spoo, Mo. Date signed _____

994 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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 J. Schaefer

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.

X