7. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 8 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40640

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1359

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 Hrs. (Specify whether years, months or days)
In this community: 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Buchanan
(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No.: 1319 N. 3rd
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: LEOLA E SPRINGS
3. (b) If veteran, name war: no
3. (c) Social Security No.: none
4. Sex: Female
5. Color or race: white
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Alfred
6. (c) Age of husband or wife if alive: 20 years
7. Birth date of deceased: June 26 1923 (Month) (Day) (Year)
8. AGE: Years 22 Months 5 Days 18 If less than one day hr. min.
9. Birthplace: Holt Co. Mo. (City, town, or county) 0 (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER
12. Name: Edward Graham
13. Birthplace: Holt, Co. Mo. (City, town, or county) 0 (State or foreign country)
MOTHER
14. Maiden name: Orah Smith
15. Birthplace: Holt Co. Mo. (City, town, or county) 0 (State or foreign country)
16. (a) Informant: Alfred Springs Husband
(b) Address: 1319 N. 3rd. St. Joseph
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/16/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Highland Cemetery
18. (a) Signature of funeral director: Rupp Funeral Home
(b) Address: 6054 Pryor St. Joseph Mo.
19. (a) Dec 26-1945 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec day: 14th A. year: 1945 hour: 1:15 minute: 0 M.
21. I hereby certify that I attended the deceased from 13th December 1945 to 14th December 1945 that I last saw her alive on 14th December 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lobar Pneumonia	2 days.
Due to	
Due to	

Other conditions (Include pregnancy within 3 months of death): Cardiac decompensation (Acute)
Major findings: Of operations:
Of autopsy: 108

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?
While at work? (Specify type of place) (e) Means of injury: 0
23. Signature: [illegible] M.D. (M. D. or other)
Address: Savannah Mo. Date signed: 12-14-45

1428 (Licensed Embalmer's Statement on Reverse Side)

JUN 3 1947

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. Mollie E. Siderfaden Fox

Licensed Embalmer No. #235

P. O. Address St. Joseph, 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.