

FILED MAY 9 1946

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 347

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:
317 W. Locust /
(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. 317 W. Locust 6
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Mary Ellen Bailey

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
year 1946 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from Apr 3, 1946
to April 23, 1946
that I last saw her ER alive on April 23
and that death occurred on the day and hour stated above.

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: October 4, 1877
(Month) (Day) (Year)

Immediate cause of death
Myocardial Congestion 2 days

8. AGE: Years 68 Months 6 Days 18
If less than one day hr. min.

Due to Pulmonary Tuberculosis 10 yrs

9. Birthplace Cole Co. Mo. Mo.
(City, town, or county) (State or foreign country)

Other conditions Toxic Hemoglobinemia 3 mos
(Include pregnancy within 3 months of death)

10. Usual occupation House Wife

Major findings:
Of operations _____
Of autopsy 13K

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

11. Industry or business At home

MOTHER FATHER

12. Name William Bridges

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

14. Maiden name Mary Satterfield

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

16. (a) Informant Mrs. Grace House

(b) Address 317 W. Locust, Spfld, Mo.

17. (a) Burial (b) Date thereof 4-25-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Harshwood

18. (a) Signature of funeral director Springfield, Mo.

(b) Address Springfield, Mo.

19. (a) 4-24-46 (b) W. Handley
(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) 2

While at work? _____ (Specify type of place)
Means of injury _____

23. Signature William J. Campion (M. D. or other) MD

Address Springfield, Mo. Date signed 4-23-46

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

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

Ogilby Stone Jr.

Licensed Embalmer No.....

4176

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