

S. No. 2
1-8-43
5-17-39
P1 X37823

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

12828

State File No. _____

FILED MAY 9 1946
Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 356

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
Josephine Nursing Home 631 S Grant
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether years, months or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
Street No. 631 S Grant
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country None

3. (a) PRINT FULL NAME Sarah Irene DeFrese
3. (b) If veteran, name war None
3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 24
year 1946 hour 11:00 minute P. M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife (UNK) DeFrese
6. (c) Age of husband or wife if alive Deceased
7. Birth date of deceased Aug 8, 1894
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4, 24, 1946 to 4, 24, 1946
that I last saw her alive on 4, 24, 1946
and that death occurred on the date and hour stated above.

8. AGE: Years 106 Months 8 Days 16
If less than one day hr. ____ min. ____

Immediate cause of death
Malnutrition-senility-gradually failing for long time. Since she was almost 102 yrs. of age, she just petered out
Duration _____

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

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

10. Usual occupation Housekeeper
11. Industry or business House work

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

12. Name (UNK) Fender
13. Birthplace Falk County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN
15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant Dale P. Smith
7310 Cherry Springfield MO
(b) Address _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

17. (a) Removal Removal (b) Date thereof Apr. 26, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Prescent Okla.

(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 _____

18. (a) Signature of funeral director Stillard E. Erwin
(b) Address Springfield, MO

23. Signature J. J. Smuck (M. D. or other) _____
Address Springfield, Mo. Date signed 4, 25, 46

19. (a) 4-25-46 (b) 5 M. Handy
(Date received local registrar) (Registrar's signature)

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

11733

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, *Willard B. Erwin*

Licensed Embalmer No. *3092*

P. O. Address, *Palmar, 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.

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