No. 2
I—2-43
5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 12902

FILED APR 30 1946

Registration District No. 128 Primary Registration District No. 5466 Registrar's No. 304

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Rural-N. Campbell Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Ozark Osteopathic Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Rural-Springfield-N. Campbell Twp.
(If outside city or town limits, write "RURAL")

(d) Street No. Route II
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Sarah Barbara Nagel

3. (b) If veteran, name war No.

3. (c) Social Security No. No

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 Feb (Month) 15, (Day) 1869 (Year)

8. AGE: Years	Months	Days	If less than one day
77	1	20	..... hr. ..... min.

9. Birthplace Henry Co. Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business .....

MOTHER FATHER

12. Name Unknown

13. Birthplace Unk. (City, town, or county) Unk. 9 (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unk. (City, town, or county) Unk. 9 (State or foreign country)

16. (a) Informant Mrs. J.R. Steele

(b) Address Springfield Rt. II

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-30-46 (Month) (Day) (Year)

(c) Place: burial ~~cremation~~ Fairbury, Neb.

18. (a) Signature of funeral director [illegible]

(b) Address Springfield Mo

19. (a) 4-8-46 (Date received local registrar) (b) Dr M Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5 year 1946 hour 8 minute 35 P.M.

21. I hereby certify that I attended the deceased from MAR-24, 1946, to APRIL 5, 1946 that I last saw h.e.a. alive on APRIL-5, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
INTESTINAL OBSTRUCTION	
Due to PARALYTIC ILEUS	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

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 .....

23. Signature D. F. Youell (M. D. or other) DO

Address Springfield, Mo. Date signed 5/6/46

111

(Licensed Embalmer's Statement on Reverse Side)

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

11807

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 Roy Adams

Licensed Embalmer No. 1763

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.