

Registration District No. **27 1946**

Primary Registration District No. **2000**

2000

423

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:
Hill Rest Home, 459 Cherry 4
(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 **Missouri** (b) County **Greene**
(c) City or town **Springfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **919 S. Weaver**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT **MRS. BERTIE BAXTER**
FULL NAME

3. (b) If veteran, name war **Nona** 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 **John W. Baxter** 6. (c) Age of husband or wife if alive **UNK.** years

7. Birth date of deceased **December 13, 1875**
(Month) (Day) (Year)

8. AGE: Years **70** Months **5** Days **2** If less than one day hr. min.

9. Birthplace **Bolivar, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Home**

11. Industry or business

12. Name **UNK.**

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

14. Maiden name **(UNK) Covington**

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

16. (a) Informant **John W. Baxter**

(b) Address **919 S. Weaver - SPED, Mo.**

17. (a) **Burial** (b) Date thereof **5/17/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Park Cemetery**

18. (a) Signature of funeral director **ALMA LOHMEYER FUNERAL HOME**

(b) Address **534 St. Louis St., Springfield, Mo.**

19. (a) **5-17-46** (b) **W. W. Handley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **15**
year **1946** hour minute **15** M.

21. I hereby certify that I attended the deceased from **Feb**
1945 to **May 15** 19**46**
that I last saw him alive on **May 17** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death

Chronic Nephritis
Due to **Arteriosclerosis**

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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 **W. W. Handley** (M. D. or other)

Address **Sped, Mo.** Date signed **5/17/46**

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

39
2
6

FEB 25 1949

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 Frank Gable

Licensed Embalmer No. 4140

P. O. Address Springfield, Missouri

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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