

No. 2
1-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16296

State File No.
Registrar's No. 442

Registration District No. 128 Primary Registration District No. 2,000

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

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:
539 West Webster St., /
(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,
(If outside city or town limits, write "RURAL")
(d) Street No. 539 West Webster St.,
(If rural, give location) _____
(e) Citizen of foreign country? No. (Yes or No) _____
If yes, name country _____

3. (a) PRINT FULL NAME Mary Isabelle Craig.
3. (b) If veteran, name war None
3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 21,
year 1946 hour 3 minute 30 P. M.
21. I hereby certify that I attended the deceased from 5-11
1946 to 5-21 1946
that I last saw h.e. alive on 5-21 and that death occurred on the date 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 Del. years
7. Birth date of deceased February 28, 1863
(Month) (Day) (Year)

Immediate cause of death Acute Heart failure Duration 12 hrs.
Due to Chronic Myocarditis 140
Due to _____

8. AGE: Years Months Days If less than one day
83 2 25 hr. _____ min. _____

Other conditions Senility
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy 730
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace Mt. Olivette Ky. /
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

11. Industry or business At Home
12. Name Shioman Stout
13. Birthplace UNK. Ky. /
(City, town, or county) (State or foreign country)
14. Maiden name Letha Moore
15. Birthplace UNK. Ky. /
(City, town, or county) (State or foreign country)

16. (a) Informant William J. Craig,
(b) Address Springfield, Mo.
17. (a) Burial (b) Date thereof 5-23-46
(Burial, cremation, or removal) (Month) (Day) (Year)

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)
While at work? _____ (e) Means of injury 0

(c) Place: burial or cremation Hazelwood Cem.
18. (a) Signature of funeral director J. W. Klingner & Co.
(b) Address Springfield Mo.
19. (a) 5-22-46 (b) W. H. Handley
(Date received local registrar) (Registrar's signature)

23. Signature P. E. Feller (M. D. or other) _____
Address Springfield, Mo. Date signed 5/24/46

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed.....

Licensed Embalmer No. 4071

P. O. Address Springfield

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