

FILED MAY 27 1946  
Registration District No. 28

Primary Registration District No. 2000

Registrar's No. 389

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: St. Johns Hospital 0  
(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 39  
Rural  
(c) City or town Springfield - SCAMMELL TWP 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. (1230 Whiteside) Route #3 0  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5  
year 1946 hour 4 minute 15 AM

21. I hereby certify that I attended the deceased from 5-4, 1946 to 5-5, 1946  
that I last saw h. cl alive on 5-4, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Streptococcus Meningitis  
Due to Probable old Brain abscess  
Duration 36 hr

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

3. (a) PRINT FULL NAME Patty Sue Gott

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 Single 1

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased March 25, 1934  
(Month) (Day) (Year)

8. AGE: Years 12 Months 1 Days 10 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation In School

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Joe Gott

13. Birthplace Strafford Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Ray Long

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

16. (a) Informant Joe B Gott

(b) Address 1230 Whiteside, SPED., Mo.

17. (a) Burial (b) Date thereof May 7, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director J. W. Klingner & Co.

(b) Address Springfield, Mo.

19. (a) 5-7-46 (b) B. W. Handy  
(Date received local registrar) (Registrar's signature)

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

15133

19  
2  
6

2X

**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.....

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.

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