

FILED DEC 24 1946
128

Registration District No. _____

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution: Springfield Baptist Hospital
(d) Length of stay: In hospital or institution 2 weeks 4 days
In this community 20 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(d) Street No. 2115 N. ROBERSON AVE.
(e) Citizen of foreign country? NO

3. (a) PRINT FULL NAME OPAL MAPES BOSHE

3. (b) If veteran, name war None 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William Boshe 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased October 26, 1902

8. AGE: Years 44 Months 0 Days 28 If less than one day hr. _____ min. _____

9. Birthplace Ray County, Missouri

10. Usual occupation House wife

11. Industry or business House wife

12. Name Jim Kincaid

13. Birthplace Ray County, Missouri

14. Maiden name Campbell

15. Birthplace no record

16. (a) Informant William Boshe

(b) Address 2115 N. ROBERSON AVE., Springfield, MO.

17. (a) Burial (b) Date thereof Nov 28 1946

(c) Place: burial or cremation East Lawn Cemetery

18. (a) Signature of funeral director Fred C. Thoms

(b) Address Springfield, MO.

19. (a) 11-27-46 (b) W. J. Handley

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 24 year 1946 hour 12 minute 20 P. M.

21. I hereby certify that I attended the deceased from Oct 28, 1946 to Nov 24, 1946 that I last saw her alive on Nov 24, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Metastatic carcinoma of abdominal visceral & ascites Duration approx 2 mo.

Due to Primary Carcinoma Left Breast 1 yr(?)

Due to Amputation 5 Mo prior

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

Major findings: Of operations _____

Of autopsy 50

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) _____

23. Signature James A. O'Brien (M. D. or other) M.D.

Address 230 1/2 E. Commercial Date signed 11/24/46

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

MOTHER FATHER

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..... *Ralph H. T. Green*.....

Licensed Embalmer No..... 3691.....

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.