

No. 2
1-5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40205
State File No. _____
Registrar's No. 1029

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution Burge Hospital
(d) Length of stay: In hospital or institution 27 days
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Stone 104
(c) City or town Crane RR 2
(d) Street No. _____
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Luerona Ruth Cordwell
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex Female / race White
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 11 1934

8. AGE: Years 12 Months 11 Days 7
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Joney Cordwell
13. Birthplace Joney County Mo
14. Maiden name Vera Scott
15. Birthplace Crane Mo

16. (a) Informant Parents
(b) Address Crane Mo RR 2
17. (a) Burial, cremation, or removal
(b) Date thereof 12-20-46
(c) Place: burial or cremation Crane, Masonic Cem

18. (a) Signature of funeral director J. W. Maples
(b) Address Clever, Mo.
19. (a) 12-21-46 (b) W. E. Handley M.D.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month December day 20
year 1946 hour 4 minute 15 P.M.
21. I hereby certify that I attended the deceased from 15 December 1946 to 20 December 1946
that I last saw her alive on 20 December 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Acute rheumatic fever
Duration _____

Due to _____
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ Means of injury _____
23. Signature P. M. K. _____ (M. D. or other) M.D.
Address Springfield, Mo. Date signed 21 Dec 46

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

39019

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... *J. W. Maples*
Licensed Embalmer No. *2985*
P. O. Address *Clever - 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.