

S. No. 2
M-5-43
7-5-17-39
I X38671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40274

FILED DEC 24 1946
128

Registration District No. _____

Primary Registration District No. 2000

Registrar's No. 956

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:
459 Cherry St. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 37

(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")

(d) Street No. 2230 Travis Ave., 6
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country _____

3. (a) PRINT Ellen E. Taylor
FULL NAME

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 14 1860
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 28
year 1946 hour 6 minute 00 A. M.

21. I hereby certify that I attended the deceased from 10-10, 1944, to 11-28, 1946
that I last saw her alive on 10/20, 1946
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

86	7	14	hr. min.
----	---	----	----------

Immediate cause of death Cerebral Hemorrhage
with Paralysis 10-10-46

Due to Hyperpnea

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

Major findings: no

Of operations: no

Of autopsy: no 11-29-46

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

10. Usual occupation House Wife

11. Industry or business At Home

12. Name Andrew J. Lamar

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

14. Maiden name Chapman

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

16. (a) Informant Wilbur L. Taylor

(b) Address R. F. D. 10 Springfield Mo.

17. (a) Burial (b) Date thereof 12-2-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Comfort Cem.

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

(b) Address Springfield Mo.

19. (a) 12-2-46 (b) W. E. Handy M.D.
(Date received local registrar) (Registrar's signature)

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)

(c) Means of injury _____

23. Signature J. F. Freeman (M. D. or other) _____
Address Springfield Mo. Date signed 11-29-46

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

J. B. Klingner
.....
Licensed Embalmer No. *3352*
.....
P. O. Address.....

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.