

No. 2  
12-45  
17-39  
X47070

State File No. \_\_\_\_\_

Registrar's No. 126

FILED FEB 28 1947

Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

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. Joseph's Hosp  
819 W. Phelps  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Days  
(Specify whether years, months or days)

In this community 5 Days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield  
(If outside city or town limits, write "RURAL") 6

(d) Street No. 819 W. Phelps  
(If rural, give location) 0

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Susan Dale Harris

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 10  
year 1947 hour 4 minute 55a. M.

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb. 5 1947  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 5 1947, to Feb 10 1947  
that I last saw her alive on Feb 10, 1947  
and that death occurred on the date and hour stated above.

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

Immediate cause of death Intracerebral hemorrhage 12-14 hrs.  
Due to Cause unknown

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

Other conditions Associated cellulitis of abdominal wall 6 hrs.  
(Include pregnancy within 3 months of death)

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

12. Name Lester Harris

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

14. Maiden name Margaret Pratt

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

Major findings: Of operations none 12 1/2

Of autopsy none 12 1/2

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

16. (a) Informant Lester Harris

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 2/10/47  
(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? \_\_\_\_\_

(c) Place: burial or cremation Eastlawn

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 2-11-47 (b) N.E. Handley MD  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury 0

23. Signature C.C. Conrad (M. D. or other) M.D.  
Address Springfield, Mo. Date signed 2-10-47

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

MOTHER FATHER

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**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.

*This body not embalmed.*

Signed.....

Licensed Embalmer No.....

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.**