

No. 2  
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-17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 21 1947**  
Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**  
Primary Registration District No. 2000

Dr. Feller  
State File No. 8633  
Registrar's No. 174

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:  
Burger-Connelly Rest Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 Months  
(Specify whether  
In this community 48 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 854 N. Main  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Gertrude Marie Hall  
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 Married  
6. (b) Name of husband or wife Lon Hall 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased August 27 1898  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb. day 28  
year 1947 hour 8 minute 55p. M.  
21. I hereby certify that I attended the deceased from 10-14  
1947 to 2-28-1947  
that I last saw her alive on 2-28  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
48 6 1 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death myocarditis with decompensation & anemia secondary  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Other conditions (include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
12. Name James Rutledge  
13. Birthplace unknown Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Ica Baldwin  
15. Birthplace unknown Missouri  
(City, town, or county) (State or foreign country)

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) (e) Means of injury \_\_\_\_\_

16. (a) Informant Lon Hall  
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 3/2/47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director H.H. Lonmeyer  
(b) Address Springfield, Mo.

19. (a) 3-3-47 (b) W. J. Handley M.D.  
(Date received local registrar) (Registrar's signature)

23. Signature C. E. Feller (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo. Date signed 3-1-47

Duration 4 mo  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

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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.

Signed.....

Licensed Embalmer No. 2457

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.