

No. 2
-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8708**
Registrar's No. **225**

FILED MAR 31 1947
Registration District No. **128**

Primary Registration District No. **5466**

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

1. PLACE OF DEATH:
(a) County **Greene**
(b) City or town **Springfield-Rural S. Campbell Sup**
(c) Name of hospital or institution: **Osteo Hosp.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 Hours**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) City or town **Springfield** (b) County **Greene**
(If outside city or town limits, write "RURAL")
(c) Street No. **410 1/2 E. Commercial**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Edith Fleeman**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **unknown**
(Month) (Day) (Year)

8. AGE: Years **55** Months **?** Days **?**
If less than one day _____ hr. _____ min.

9. Birthplace **Boone County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Home**

MOTHER FATHER

11. Industry or business _____
12. Name **Lonius Rohr**
13. Birthplace **Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lonius Rohr**
(b) Address **Springfield, Mo.**
17. (a) **Burial** (b) Date thereof **3/16/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Mary**

18. (a) Signature of funeral director **H.H. Lohmeyer**
(b) Address **Springfield, Mo.**
19. (a) **3-13-47** (b) **H.H. Lohmeyer**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **12**
year **1947** hour **12** minute **02a.** M.

21. I hereby certify that I attended the deceased from **Mar. 9, 1947** to **Mar. 12, 1947**
that I last saw him alive on **March 11, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Sub acute bacterial endocarditis**

Due to _____
Due to _____

Other conditions **Influenza**
(Include pregnancy within months of death)

Major findings:
Of operations _____
Of autopsy _____

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 **fall**
23. Signature **Willard May** (M. D.)
Address **Willard, Mo.** Date signed **3/12/47**

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

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.....

Walter E. Hamlin

Licensed Embalmer No.....

3808

P. O. Address.....

Springfield MA

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.