

S. No. 2
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S-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Langston
State File No. 13132
Registrar's No. 374

FILED MAY 5 1947

Registration District No. 128 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. John Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 Hours
(Specify whether years, months or days) 5 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 39
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No. 930 E. Dale 6
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mildred Ann Hurd
3. (b) If veteran, name war No 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Homer Hurd
6. (c) Age of husband or wife if alive 6 years
7. Birth date of deceased March 15 1923
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
24 1 6 hr. min.

9. Birthplace Harrison Arkansas
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

11. Industry or business _____
12. Name Bennie Keele
13. Birthplace Harrison Arkansas
(City, town, or county) (State or foreign country)
14. Maiden name Oma Vanzant
15. Birthplace Harrison Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Homer Hurd
(b) Address Springfield, Mo.
17. (a) Burial (b) Date thereof 4/24/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Harrison, Ark.

18. (a) Signature of funeral director H. H. Lonmeyer
(b) Address Springfield, Mo.
19. (a) 4-21-47 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21
year 1947 hour 1 minute 30a. M.
21. I hereby certify that I attended the deceased from 4/20 1947 to 4/21 1947
that I last saw her alive on 4/20 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid hemorrhage about 10 hrs. Spontaneous
Duration _____
Disease reprints chronic

Other conditions pregnant about 7 months
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 31B
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? _____ (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 _____
23. Signature W. Robert Langston (M. D. or other) MD
Address Springfield Date signed 4/21/47

(Licensed Embalmer's Statement on Reverse Side)

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

7
2
6

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 (Roy W. 771-2000-20)

Licensed Embalmer No. 1432

P. O. Address 1220 N. 1st St. / No.

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.