

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

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:  
1006 N. Rogers  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 Months  
(Specify whether 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. 1106 N. Rogers  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Martha Flora Wilson  
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 John F. Wilson  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec. 22 1872  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>3</u>	<u>5</u>	hr. min.

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

10. Usual occupation Housewife

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

MOTHER FATHER  
12. Name E. A. Tomlinson  
13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Margaret Dawson  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant John F. Wilson

(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) Lebanon, Mo.  
(b) Date thereof 4/29/47  
(Month) (Day) (Year)

(c) Place: burial or cremation Lebanon, Mo.

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

(b) Address Springfield, Mo.

19. (a) 4-28-47 (b) W. J. Handley M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27  
year 1947 hour 1 minute 23a. M.  
21. I hereby certify that I attended the deceased from April 27 1947  
to April 27 1947  
that I last saw her alive on April 27 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 1 day

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations g. s. p.  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
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? Yes

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

23. Signature G. F. Reichtold M.D. (M. D. or other) M.D.

Address 318 1/2 E. Commercial Springfield Mo. Date signed 28 April 1947

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

---

---

**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. Hamilton*

Licensed Embalmer No. *3808*

P. O. Address *Springfield, Mo.*

**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.**