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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 6 1947
Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Feller
State File No. 30935
Registrar's No. 838

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: Baptist Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day (Specify whether years, months or days)
In this community 1 Day

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. 772 Mt. Vernon
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Malady Infant
3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex Male 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 Sept. 21 1947
(Month) (Day) (Year)

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

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

10. Usual occupation Infant

11. Industry or business

12. Name Ralph Malady

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

14. Maiden name Marjorie Smith

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

16. (a) Informant Ralph Malady

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 9/23/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

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

(b) Address Springfield, Mo.

19. (a) 9-23-47 (b) H. H. Lohmeyer MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 22
year 1947 hour 2 minute 30a. M.

21. I hereby certify that I attended the deceased from Sept 21, 1947 to Sept 22, 1947.
that I last saw her alive on Sept 21, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Premature birth
Due to Cause unknown

Due to

Other conditions (Include pregnancy within 3 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

23. Signature C. E. Feller (M. D. or other)
Address Springfield Mo Date signed 9/27/47

Duration

5 1/2 hr

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.....

This body was not embalmed.

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.