

No. 2  
2-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30943**  
Registrar's No. **810**

FILED OCT 6 1947  
128  
Registration District No.

Primary Registration District No. **2000**

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

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:  
Springfield Baptist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community 11 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. 720 South Holland Avenue  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME MABEL RUSH

3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lonnie Oliver Rush  
6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased Aug 24 1904  
(Month) (Day) (Year)

8. AGE: Years 43 Months 0 Days 20  
If less than one day hr. min.

9. Birthplace Homer Okla  
(City, town, or county) (State or foreign country)

10. Usual occupation Teacher

11. Industry or business nurse aide

12. Name W. P. Yazel

13. Birthplace Rushville Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Amaria Benedict

15. Birthplace unk. Ill  
(City, town, or county) (State or foreign country)

16. (a) Informant Clinical Records of Hospital  
(b) Address Springfield, Missouri

17. (a) Removal (b) Date thereof 9/13/1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dunnegan, Missouri

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home  
(b) Address Springfield, Missouri

19. (a) 9-17-47 (b) W. H. Handley MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 13,  
year 1947 hour 4: minute 40 P. M.

21. I hereby certify that I attended the deceased from Sept 13 1947 to Sept 13 1947  
that I last saw h. w. alive on Sept 13 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-respiratory failure  
Due to Ecdypsis Duration 12 hrs  
Due to Pregnancy Duration 9 mos  
Other conditions (Include pregnancy within 3 months of death) none  
Major findings: Of operations none Of autopsy none  
PHYSICIAN W. H. Handley M.D.  
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 W. H. Handley M.D. (M. D. or other) MD  
Address Springfield, Mo Date signed 9-17-47

**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.....

*Frank S. Coffman Jr.*, Registered Apprentice No. *16*  
working under my personal supervision.

Signed *Jesse E. Hindee*

Licensed Embalmer No. *22837*

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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 607  
Registrar's No. 810

Registration District No. 124 Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mabel Rush

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased aug 2 (Month) (Day) (Year)

8. AGE: Years 43 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Okla.

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I had seen \_\_\_\_\_ and that death occurred on the date and hour stated above. \_\_\_\_\_ immediate cause of death.

Due to there was not a delivery

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 [Signature] (M. D. or other) \_\_\_\_\_

Address Springfield, Mo Date signed 10-11-47

SUPPLEMENTARY

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

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

S-30943