

FILED OCT 27 1947  
Registration District No. 128

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 3 days (Specify whether  
In this community 3 days  
years, months or days)

3. (a) PRINT FULL NAME LUDWIG INFANT  
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 Single  
6. (b) Name of husband or wife Single  
6. (c) Age of husband or wife if alive 3 years (Month) (Day) (Year) October 3, 1947

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>3</u>	hr. min.

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

10. Usual occupation Infant

11. Industry or business Infant

MOTHER FATHER {  
12. Name Charles Ludwig  
13. Birthplace Ava, Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Pauline Marie Longston  
15. Birthplace Muskogee, Oklahoma  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Charles Ludwig (Father)  
(b) Address 939 Kings Avenue

17. (a) Burial (b) Date thereof 10/7/1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood Cemetery  
Alma Lohmeyer Funeral Home

18. (a) Signature of funeral director Springfield, Missouri  
(b) Address

19. (a) 10-18-47 (b) W. H. Handley, Jr.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Greene 89  
(c) City or town Springfield 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 939 Kings Avenue 6  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No) 0  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 6,  
year 1947 hour 2 minute 15 P. M.

21. I hereby certify that I attended the deceased from Oct 3, 1947 to Oct 6, 1947  
that I last saw her alive on Oct 6, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Starvation & dehydration  
Duration 3 days

Due to Congenital anomalies of intestinal tract 3 days

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: Congenital bands adhesion and other bowel malformations  
Of operations None  
Of autopsy None  
PHYSICIAN None  
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) (c) Means of injury  
23. Signature [Signature] (M. D. or other) M.D.  
Address Springfield, MO Date signed 10-6-47

**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.....

*Lee Mason*....., Registered Apprentice No. *477*  
working under my personal supervision.

Signed *Jewell C. Kuddle*.....

Licensed Embalmer No. *2831*.....

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.**