

S. No. 2
M-1/47
y. 5-17-39

FILED JAN 12 1948
Registration District No.

Primary Registration District No. **5465**

Registrar's No. **1135**

1. PLACE OF DEATH:

(a) County **Greene**

(b) City or town **Rural Springfield, N. Campbell**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution
2959 N. Grant Ave.,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
7 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Greene**

(c) City or town **Springfield - Rural**
(If outside city or town limits, write "RURAL")

(d) Street No. **2959 N. Grant Ave.**
(If rural, give location)

(e) Citizen of foreign country? **No.** (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME **Sophia Mueller**

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 **Widow**

6. (b) Name of husband or wife **Unknown**

6. (c) Age of husband or wife if alive **42** years

7. Birth date of deceased **February 5, 1865**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
82	10	24hr.min.

9. Birthplace **St. Louis, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House Wife**

11. Industry or business **At Home**

12. Name **August Verich**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Fessekins**

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **George Ruhl,**

(b) Address **2959 N. Grant Ave., Spg. Mo.**

17. (a) **Removal** (b) Date thereof **12-30-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valmeyer Ill.**

18. (a) Signature of funeral director **J. W. Klingner & Co.**

(b) Address **Springfield Mo.**

19. (a) **12-30-47** (b) **W. Z. Hareddy**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **29** th
year **1947** hour **10** minute **30** P. M.

21. I hereby certify that I attended the deceased from **5 months** 19 **1947** to **Dec 29** 19 **47**
that I last saw him **alive** on **Dec 25** 19 **47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute cardiac affecting heart - had chronic symptoms.**

Due to **decomposition of vessel**

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN

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?.....
(Specify type of place)

23. Signature **E. C. Evans** (M. D. or other)

Address **815 1/2 Colby** Date signed **12/30/47**

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

MOTHER FATHER

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.....

Ogle Stone Jr.

Licensed Embalmer No.....

4176

P. O. Address.....

Springfield

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.