

FILED FEB 6 1948

Registration District No. 128

Primary Registration District No. 2000

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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: Burge Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community 5 days 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. 1875 N. Campbell (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Kathleen Maria Wells

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

4. Sex female 5. Color of WHITE 6. (a) Single, widowed, married, divorced no

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Jan 25 48
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 5 If less than one day hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business no

12. Name Fredonia Dean Wells

13. Birthplace Rebekah Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Kelly Jo Maggi

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

16. (a) Informant Fredonia Dean Wells

(b) Address 1875 N Campbell

17. (a) Burial (b) Date thereof 1/31/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary

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

(b) Address Springfield, Mo.

19. (a) 1-31-48 (b) W. J. Handley MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30
year 1948 hour 6:00 minute 45 p.m.

21. I hereby certify that I attended the deceased from 1-25-48 19____ to 1-30-48 19____
that I last saw her alive on 1-30-48 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: Congenital Heart Disease
Interventricular Septal Defect
Pneumonia
Expected Date March 15th

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

Major findings: Of operations _____
Of autopsy _____

Duration

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?
While at work? _____ (Specify type of place) (e) Means of injury 0 ✓

23. Signature E. J. Delmonte (M. D. or other) _____
Address 420 Med. Coll. Bldg. Springfield Date signed 1-31-48

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.