S. No. 2
—11-10-39
v. 17-39
X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 22 1948

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18487

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 72

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Urel Washington Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution State Hospital #3.2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 yrs. 9 mos. 4 da. (Specify whether years, months or days)
In this community 30 yrs - 9 Mos. 4 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL") 6
(d) Street No. 2101 Travis 1
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Louisa Hughes.
3. (b) If veteran, name war —
3. (c) Social Security No. None
4. Sex F 1
5. Color or race W
6. (a) ~~Single, widowed~~, married, ~~divorced~~ M 1
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased DK - (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
apx-	80			hr. min.

9. Birthplace Missouri (City, town, or county) 0 (State or foreign country)
10. Usual occupation House wife
11. Industry or business —
FATHER
12. Name M-Hughes
13. Birthplace Missouri (City, town, or county) 0 (State or foreign country)
MOTHER
14. Maiden name Reko
15. Birthplace Missouri (City, town, or county) 0 (State or foreign country)
16. (a) Informant M W Hughes Son
(b) Address 2101 Travis Springfield Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-15-48 (Month) (Day) (Year)
(c) Place: burial or cremation Springfield, Mo.
18. (a) Signature of funeral director Kleiger Funeral Home
(b) Address Springfield Mo.
19. (a) 5-17-48 (Date received local registrar) (b) Kathryn Yancey (Registrar's signature) 3211

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 14 year 1948 hour 1045 minute P. M.
21. I hereby certify that I attended the deceased from 6-1- 1946 to 5-14- 1948 that I last saw her alive on 5-14- 1948 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
(1) Syphilitic Meningo Encephalitis	30 yrs+
(2) Due to Fracture Left Femur due to Fall on floor - 5-10-1948	4 Days
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 5-10-1948 100
(c) Where did injury occur? State Hospital #3 (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)
While at work? (e) Means of injury
23. Signature J. R. Bunch (M. D. ~~or other~~) 0
Address State Hospital #3 Date signed 5-14-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 4-48-550
Date Filed 5-21-48

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 Mark Eichinger

Licensed Embalmer No. 2656

P. O. Address Nevada, 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, above space should be left blank.