

FILED JUL 6 1948

Primary Registration District No. **2000**

Registrar's No. **531**

1. PLACE OF DEATH:

(a) County **SPRINGFIELD**
(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 **Aug 1 - 1947 - 10 days**
(Specify whether) **All of life**
In this community **All of life**
years, months or days

3. (a) PRINT FULL NAME **Nora Dolphin**
3. (b) If veteran, name war **none**
3. (c) Social Security No. **none**

4. Sex **f** / 1 / race **WHITE**
5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **2**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive, years (Day) (Year) **4 - 1974**

7. Birth date of deceased **Feb.** (Month) **4.** (Day) **1974** (Year)
8. AGE: Years **74** Months **4** Days **25**
If less than one day hr. min.

9. Birthplace **Webster Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **N.W.**

11. Industry or business **Housewife**

MOTHER FATHER
12. Name **Ben King (Dec)** **9**
13. Birthplace **unknown** **9**
14. Maiden name **Adelaine Grigski (Dec)**
15. Birthplace **unknown** **9**

16. (a) Informant **Mrs Nellie Gardner (sister)**

(b) Address **847 So. Campbell**

17. (a) **Burial** (b) Date thereof **7-1-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Welch Cemetery**

18. (a) Signature of funeral director **J. A. Gagne & Co**

(b) Address **Springfield Mo**

19. (a) **6-29-48** (b) **W. J. Handley MD**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Greene** **39**
(c) City or town **Springfield** **2**
(If outside city or town limits, write "RURAL") **665 E. Madison St.** **6**
(d) Street No. **665 E. Madison St.** (If rural, give location) **0**
(e) Citizen of foreign country? (Yes or No) **0**
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **28** year **1948** hour **6** minute **25** a.m.

21. I hereby certify that I attended the deceased from **June 28 1948** to **June 29 1948**
that I last saw **her** alive on **June 28 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardio-vascular-reveral disease 1 yr.**
Due to **Hypertension**
Atherosclerosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **B1W**
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
(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 **Don J. Silaby** (M. D. or other) **MD**
Address **Springfield Mo** Date signed **6-29-48**

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

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.....

Max Rhodes

Licensed Embalmer No.....

4071

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.