

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED AUG 9 1948
Registration District No. 128

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22806
Registrar's No. 650

Primary Registration District No. 2000

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:
Burger Connelly Rest Home
(If not a hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 29 days
(Specify whether
In this community: most of life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Jarvis 10 1/2
(c) City or town Brunson
(If outside city or town limits, write "RURAL")
(d) Street No. P.O. Box
(If rural, give location)
(e) Citizen of foreign country? U.S.A. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Bertha Dell Chandler
3. (b) If veteran, name war no
3. (c) Social Security No. no

20. DATE OF DEATH: Month Aug. day 2
year 1948 hour 8 a. m. minute 0 M.
21. I hereby certify that I attended the deceased from 7/20/48
1948, to 8/2/48, 1948;
that I last saw her alive on 7/30/48, 1948;
and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Jess 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: 8 20 1877
(Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage
Duration 2 wks

8. AGE: Years 70 Months 11 Days 13
If less than one day hr. min.

Due to _____
Due to _____

9. Birthplace Montreal, Canada
(City, town, or county) (State or foreign country)
10. Usual occupation House wife

Other conditions Old paralysis 5 yrs
(Include pregnancy within 3 months of death) 10 mos.

11. Industry or business _____
12. Name George Edgar Call
13. Birthplace Montreal, Canada
(City, town, or county) (State or foreign country)
14. Maiden name Magone Barber
15. Birthplace St. Ponson, N. Dakota
(City, town, or county) (State or foreign country)

Major findings:
Of operations None
Of autopsy None
Underline the cause to which death should be charged statistically.

16. (a) Informant B. W. Crummer
(b) Address Brunson MO
17. (a) Burial (b) Date thereof 8-4-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Brunson MO
18. (a) Signature of funeral director R.O. Wheelchel
(b) Address Brunson MO
19. (a) 8-4-48 (b) N.E. England MO
(Date received local registrar) (Registrar's signature)

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) _____
While at work _____ (e) Means of injury _____
23. Signature J.B. Lammson (M. D. or other) M.D.
Address Springfield, MO Date signed 8/2/48

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 *Minnie L. Whelchel*

Licensed Embalmer No. *2277*

P. O. Address *Branson 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug
Registrar's No. 650

Registration District No. 128

Primary Registration District No. 2000

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

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Bertha D. Chandler

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Aug 2
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 3 (If less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-4-98 (b) W J Handley MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 4 Year 1948 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19 _____

that I last saw him/her alive on _____, 19 _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

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 _____

(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 _____ (M, D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

S-22806