

No. 300
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5-17-39
-1 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED AUG 23 1948

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. Fitch 25988
State File No. _____
Registrar's No. 686

Registration District No. 128

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

3. (a) PRINT FULL NAME

Hattie Poulson

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife S. G. Poulson

6. (c) Age of husband or wife if alive 9 years

7. Birth date of deceased June (Month)

9 (Day) 1871 (Year)

8. AGE:

Years 77 Months 3 Days 8

If less than one day
hr. _____ min. _____

9. Birthplace Unknown
(City, town, or county)

Unknown 9
(State or foreign country)

10. Usual occupation Home

11. Industry or business _____

12. Name James Gray 9

13. Birthplace Unknown
(City, town, or county)

Unknown 9
(State or foreign country)

14. Maiden name Mary Butler

15. Birthplace Unknown
(City, town, or county)

Unknown 9
(State or foreign country)

16. (a) Informant Miss Mollie Poulson

(b) Address Springfield, Mo.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 8/18/48
(Month) (Day) (Year)

(c) Place: burial or cremation Crocker, Mo.

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

(b) Address Springfield, Mo.

19. (a) 8-20-48
(Date received local registrar)

(b) W. S. Hummel MD
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Aug. day 17
year 1948 hour 1 minute 0 P. M.

21. I hereby certify that I attended the deceased from Aug 12, 1948 to Aug 17, 1948; that I last saw him or alive on Aug 17, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Duration 3 days

Due to Injury of Left Hip 2 Weeks

Due to _____

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

Major findings: Of operations 160 W

Of autopsy 17

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) Fall all caused fracture of left hip
(b) Date of occurrence 1-23
(c) Where did injury occur? Springfield, Greene Mo
(City, town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? No (Specify type of place) (e) Means of injury Fall

23. Signature W. S. Hummel MD (M. D. or other) MD
Address Springfield, Mo Date signed 8-20-48

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

MOTHER FATHER

OCT 28 1956

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.....

Walter E. Hamilton

Licensed Embalmer No.

3808

P. O. Address.....

Springfield, 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.