

39
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 24 1949

State File No. 914

51

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (in this place) 42 years		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		d. STREET ADDRESS (If rural, give location) 1429 West Olive		
d. FULL NAME OF HOSPITAL OR INSTITUTION 1429 West Olive				d. STREET ADDRESS (If rural, give location) 1429 West Olive				
3. NAME OF DECEASED (Type or Print) a. (First) Elsie b. (Middle) C c. (Last) Harpool			4. DATE OF DEATH (Month) (Day) (Year) January 13 1949					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH September 2, 1856		
9. AGE (in years last birthday) 92		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 100 YRS. Hours _____ Mins. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper			10b. KIND OF BUSINESS OR INDUSTRY House Keeping		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Harry Harpool			13b. MOTHER'S MAIDEN NAME Tilisha Melton			14. NAME OF HUSBAND OR WIFE ----		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs Margie Griffin, Springfield, Mo. ADDRESS _____				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Septic Sepsis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 422"2					INTERVAL BETWEEN ONSET AND DEATH 4/3 4/3	
19a. DATE OF OPERATION 1-22-49		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from 1-1-1949 to 1-18-1949 , that I last saw the deceased alive on 1-18-1949 , and that death occurred at 4:15 Pm. , from the causes and on the date stated above.								
23a. SIGNATURE Paul A. Stetler M.D. (Degree or title)				23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 1-25-49		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan 21, 1949		24c. NAME OF CEMETERY OR CREMATORY Greenlawn		24d. LOCATION (City, town, or county) (State) Springfield Missouri		
DATE REC'D BY LOCAL REG. 1-22-49		REGISTRAR'S SIGNATURE W. J. Handley M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Alma Lohmeyer Funeral Home, Springfield, Mo. ADDRESS _____				

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Jewell E. Wundt
working under my personal supervision.

Student Embalmer No. *300*

Signed.....
Student Embalmer

Signed *Jewell E. Wundt*

Licensed Embalmer No. *2831*

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.