

FILED APR 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Lemmon Jr. 12040
State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>381</u>		
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. <u>Missouri</u> b. COUNTY <u>Greene</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (In this place) <u>48 Yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		2 6 0		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>1501 University</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ada</u>			b. (Middle)			c. (Last) <u>Doggrell</u>		
4. DATE OF DEATH (Month) (Day) (Year) <u>April 27, 1949</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 2 1875</u>		
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months Days		IF UNDER 1 WKS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Sam Gradwohl</u>			13b. MOTHER'S MAIDEN NAME <u>Josephine Wise</u>			14. NAME OF HUSBAND OR WIFE <u>John H. Doggrell</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John H. Doggrell Springfield, Mo.</u>				
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Anterior cranial hemorrhage & encephalomalacia</u> DUE TO (b) <u>Possible brain tumor</u> DUE TO (c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>3 3/4</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3-4 wks.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? <input checked="" type="checkbox"/>				
22. I hereby certify that I attended the deceased from <u>Aug. 1942</u> , to <u>4-27, 1949</u> , that I last saw the deceased alive on <u>4-26, 1949</u> , and that death occurred at <u>6:10 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Bruce Lemmon Jr. MD</u>				23b. ADDRESS <u>Spfld. Mo.</u>		23c. DATE SIGNED <u>4-27-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4/29/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Maple Park</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>7/28/49</u>		REGISTRAR'S SIGNATURE <u>W.S. Handley</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.H. Lohmeyer Springfield, Mo.</u>				

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

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.