

FILED AUG 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. R. Delzell
State File No. 23052

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 680

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 town) Springfield		c. LENGTH OF STAY (in this place) 39	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hosp.		d. STREET ADDRESS (If rural, give location) 924 N. Main	
3. NAME OF DECEASED (Type or Print) a. (First) Mollie b. (Middle) Ingram c. (Last) Allen			4. DATE OF DEATH (Month) (Day) (Year) July 29, 1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 29, 1861
9. AGE (In years last birthday) 88		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Arch F. Ingram	
13b. MOTHER'S MAIDEN NAME Mary Moore		14. NAME OF HUSBAND OR WIFE X	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT'S SIGNATURE OR NAME Frank Allen			ADDRESS Springfield, Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Obstruction of bowel		5613
ANTECEDENT CAUSES		DUE TO (b) Heart of Atherosclerosis		
		DUE TO (c) Old Post of Scur		
II. OTHER SIGNIFICANT CONDITIONS		This patient developed Cursh's valve for obstruction		
19a. DATE OF OPERATION		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) (Min.)	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 **July 27, 1949** to **July 29, 1949**, that I last saw the deceased alive on **July 24, 1949**, and that death occurred at **11 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE **H. H. Lohmeyer M.D.** (Degree or title) 23b. ADDRESS **Springfield, Mo.** 23c. DATE SIGNED **7-31-49**

24a. BURIAL, CREMATION, OR REMOVAL (Specify) **Burial** 24b. DATE **7/31/49** 24c. NAME OF CEMETERY OR CREMATORY **Maple Park** 24d. LOCATION (City, town, or county) (State) **Springfield, Mo.**

DATE REC'D BY LOCAL REG. **8-1-49** REGISTRAR'S SIGNATURE **H. H. Lohmeyer M.D.** 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **H. H. Lohmeyer Springfield, Mo.**

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

AUG 10 1949

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. Hamble*.....

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.