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

FILED SEP 6 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Dr. Pong 26619  
22 1/2  
State File No. 26619

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>772</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>35 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		d. STREET ADDRESS (If rural, give location) <u>911 W. Hovey</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>911 W. Hovey</u>				d. STREET ADDRESS (If rural, give location) <u>911 W. Hovey</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Rebecca</u>			b. (Middle) <u>Margaret</u>		c. (Last) <u>Hall</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 26. 1949</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct. 29 1871</u>		9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>New Orleans La.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Thomas Maher</u>			13b. MOTHER'S MAIDEN NAME <u>Ann Rennicks</u>		14. NAME OF HUSBAND OR WIFE <u>X</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>Clarissa Hall 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Cardiovascular Nephritic disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input 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) _____ m. _____		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 <u>Aug 3</u> , 1949, to <u>Aug 26</u> , 1949, that I last saw the deceased alive on <u>Aug 26</u> , 1949, and that death occurred at <u>5:15 pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>H. H. Lohmeyer M.D.</u>			23b. ADDRESS <u>921 E. Commercial Springfield Mo</u>			23c. DATE SIGNED <u>Aug 27 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/29/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Mary Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>8-30-49</u>		REGISTRAR'S SIGNATURE <u>W.S. Handley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H.H. Lohmeyer</u>		ADDRESS <u>Springfield, Mo.</u>	

**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.

Signed \_\_\_\_\_

*Paul J. Conway*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. *2457*

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.