

Registration District No. 218 Primary Registration District No. 2001

1. PLACE OF DEATH:  
(a) County Greene  
(b) City or town Springfield  
(c) Name of hospital or institution: 551 W. Pine St 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_

8. (a) PRINT FULL NAME ANNA MILLER LIND  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: April 4 1860

8. AGE: Years 79 Months 9 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Ind. 1

10. Usual occupation House Wife 1

11. Industry or business In home

12. Name Mrs. A. Cooper 9

13. Birthplace Ind. 9

14. Maiden name Rebecca

15. Birthplace Ind. 9

16. (a) Informant Man

17. (a) (b) Date thereof 1-14-40

18. (a) Signature of funeral director Chas. H. George

19. (a) 1-14-40 (b) Chas. H. George

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Greene  
(c) City or town Springfield  
(d) Street No. 551 W. Pine  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

20. DATE OF DEATH: Month Jan day 12  
year 1940 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw her dead alive on Jan 12, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocardosis

Due to Senility 93 1/2

Other conditions Arterio Sclerosis

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
Signature Med White (M. D. or other) MD  
Address Greene County Date signed 1/14/40

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

601 21 531 11m

**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*

*Ogle Stone Jr.*

Registered Apprentice No. *232*

working under my personal supervision.

Signed *Warren D. Noble*

Licensed Embalmer No. *4005*

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, above space should be left blank.

X