No. 2
4-13-40
-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38708

Registration District No. 318 — Primary Registration District No. 2001 — Registrar's No. 915

FILED DEC 10 1940

1. PLACE OF DEATH
(a) County: GREENE
(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 511 W. Calhoun
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days) In this community: 2

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Greene
(c) City or town: Springfield (If outside city or town limits, write "RURAL")
(d) Street No.: 511 W. Calhoun (If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years: 0

3. (a) PRINT FULL NAME: FANNIE F. HAYNES
3. (b) If veteran, name war: no
3. (c) Social Security No.: -0-
4. Sex: Female
5. Color or race: white
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Frank M. Haynes
6. (c) Age of husband or wife if alive: 74 years
7. Birth date of deceased: Oct (Month) 4 (Day) 1885 (Year)
8. AGE: Years 155 Months 1 Days 8 If less than one day ..... hr. ..... min.
9. Birthplace: Unknown (City, town, or county) Iowa (State or foreign country)
10. Usual occupation: House Wife
11. Industry or business: In home
FATHER
12. Name: Cyrus E. Collison
13. Birthplace: Unknown (City, town, or county) Virginia (State or foreign country)
MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)
16. (a) Informant: Frank M. Haynes
(b) Address: Springfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 14-1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Green Lawn Cem.
18. (a) Signature of funeral director: J. W. Dingus
(b) Address: Springfield, Mo.
19. (a) 11-14-40 (Date received by local registrar) (b) W. E. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12 year 1940 hour 4 minute 15 A.M.
21. I hereby certify that I attended the deceased from 12-3-40, 19..., to 11-12-, 1940, that I last saw her alive on 11-11-40, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma Left inguinal glands Left breast + Left lung Left axillary region — Duration
Due to: primary inguinal glands — 1 year
Due to:
Other conditions (Include pregnancy within 3 months of death): 57
Major findings: Of operations: 0
Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: C. E. Feller (M. D.) 1
Address: Springfield Mo. Date signed 11-12-40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE 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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Roy a Lawin

Licensed Embalmer No. 1763

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.