

STANDARD CERTIFICATE OF DEATH

State File No. 14611

Registration District No. 310 234 Primary Registration District No. 5449 Registrar's No. _____

1. PLACE OF DEATH:

(a) County GREENE
 (b) City or town Springfield Roberson
 (c) Name of hospital or institution:
Rt. 2, Willard, Mo.
 (d) Length of stay: In hospital or institution None
 In this community Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
 (c) City or town Rural
 (d) Street No. Rt. 2, Willard, Mo.
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Winnie Cagle Haring

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Elvin Haring 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased May 9 1884
 (Month) (Day) (Year)

8. AGE: Years 36 Months 5 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business _____

12. Name Sam King

13. Birthplace Missouri
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R. H. Musser

(b) Address Rt. 2, Willard, Mo.

17. (a) Burial (b) Date thereof 4-10-1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenfield, Mo.

18. (a) Signature of funeral director Dunn Funeral Home

(b) Address Springfield, Mo.

19. (a) 4-9-1941 (b) Mrs. Guy Freeman
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8 year 1941 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from April 20 - 41 to April 8 - 41, 1941

that I last saw him alive on April 8, 1941 and that death occurred on the date and hour stated above

Immediate cause of death Ischemic heart disease

Due to Deepen some line

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy no

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? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature D. J. Freeman (M. D. or other) _____
 Address Springfield, Mo. Date signed 7/9/41

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

39
80

29
39
X23

RECEIVED

Greene County Health Office,

County File Number 41-5-53

Date Filed 5/2/41

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

Hayd W. Fox

Licensed Embalmer No. 2910

P. O. Address 629 W. Walnut

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14611

Registration District No. 334

Primary Registration District No. 3449

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Robertson
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(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 _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Winnie Cagle Haring

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. DATE OF DEATH Month Apr day 8
year 1941 hour _____ minute _____ M.

4. Sex 7 5. Color or race w

6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased May 9 1884
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

8. AGE: Years Months Days If less than one day

56 10 29 28 hr min.

Due to _____

Due to _____

9. Birthplace (City, town, or county) _____ (State or foreign country) _____

Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation _____

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name _____

13. Birthplace (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____ (State or foreign country) _____

15. Birthplace (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-9-41 (b) Mrs Guy Freeman
(Date received local registrar) (Registrar's signature)

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 _____

23. Signature S. J. Freeman (M. D. or other) _____

Address Springfield Mo Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

