

Registration District No. 318

Primary Registration District No. 5439

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield Rural - N. Camp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
R.F.D #101
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Springfield Rural - N. Camp
(If outside city or town limits, write "RURAL")
(d) Street No. Rural (R#10) 34
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ✓

3. (a) PRINT FULL NAME ARCH H. HENOWETH

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ODA M. HENOWETH 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased JAN 21 1873
(Month) (Day) (Year)

8. AGE: Years 1 68 Months 9 Days 14 If less than one day hr. min.

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

10. Usual occupation Larynman

11. Industry or business Spire

12. Name Mrs. Chenoweth

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

14. Maiden name Unknown Unknown

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

16. (a) Informant Mrs Oda M. Chenoweth

(b) Address R#10 Springfield Mo.

17. (a) Rural (b) Date thereof Oct-29-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cem

18. (a) Signature of funeral director J.W. Kingner & Co

(b) Address Springfield Mo.

19. (a) 10-24-41 (b) W.E. Handley, M.D.
(Date received local registrar) (Registrar's signature)

48 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27
year 1941 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from 10-27-41 to Oct-27-41
that I last saw him alive on Oct-27-41
and that death occurred on the date and hour stated above.

Immediate cause of death: Valvular Heart Disease
Chronic coronary atherosclerosis
Thrombosis
Due to: Atherosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 131 P
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 0

23. Signature Wm. F. Keast (M. D. or other) 10/29/41
Address 1554 E. Paul Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....
.....
working under my personal supervision.

Signed

W. Max Rhodes

Registered Apprentice No.

Licensed Embalmer No. *4071*

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.