

FILED JUL 15 1942  
Registration District No. 378 323

Primary Registration District No. 5448

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

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield WILLARD WILFAR-DMANNA

(c) Name of hospital or institution:  
WILLARD MO. R.F.D. # 11  
(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 39

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

(d) Street No. R.F.D. # 1  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT NAME ANGIE L. HAUN.

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18  
year 1942 hour 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from Nov. 1st  
1941 to June 18, 1942  
that I last saw her alive on June 18, 1942  
and that death occurred on the date and hour stated above.

4. Sex FEMALE

5. Color or race WHITE

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

6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
Nov. 20 1867  
(Month) (Day) (Year)

7. Birth date of deceased

Immediate cause of death Senility

Duration \_\_\_\_\_

8. AGE: Years 74 Months 6 Days 28  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Arteriosclerosis and a resulting hypertension.

Due to Cardiac insufficiency and a resulting dropsy.

9. Birthplace Ky. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business In home

12. Name Dr. Robt Tinsley

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

14. Maiden name Wesley Pascoe  
(City, town, or county) (State or foreign country)

15. Birthplace Ky. 8  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: None

Of operations \_\_\_\_\_

Of autopsy None

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

16. (a) Informant Mrs. Laura Luther

(b) Address Willard Mo. R# 1

17. (a) Burial  
(Burial, cremation, or removal)

(b) Date thereof 21 42  
(Month) (Day) (Year)

(c) Place: burial or cremation Wesley Chapel

18. (a) Signature of funeral director J. W. Higgins

(b) Address Springfield Mo.

19. (a) 6-19-42  
(Date received local registrar)

(b) J. W. Higgins  
(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 Dr. R. M. Reed (M. D. or other) D.O.

Address Willard, Missouri Date signed 6/19/42

1242

City Health Office

Cad. No. 42-7-60

Date Filled 7/14/42

**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.....

..... Licensed Embalmer No.....

..... P. O. Address.....

**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.