

FILED JAN 10 1945
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STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41140
Registrar's No. 912A

Registration District No. 2000

Primary Registration District No. 2000

Registrar's No. 912A

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: **1437 WASHINGTON AVE.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1**
78 YR. (Specify whether years, months or days)

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. **1437 WASHINGTON AVE.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **VONIE FLANNERY**

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

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOW**
6. (b) Name of husband or wife **UNK.** 6. (c) Age of husband or wife if alive, **UNK.** years
7. Birth date of deceased **NOV. 3, 1866**
(Month) (Day) (Year)

8. AGE: Years **78** Months **1** Days **10** If less than one day hr. min.

9. Birthplace **GREENE CO. MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife at home**

11. Industry or business **at home**

12. Name **Thomas Johnson**
13. Birthplace **UNK. MO.**
(City, town, or county) (State or foreign country)

14. Maiden name **UNK.**
15. Birthplace **UNK. unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Anah Flannery**
(b) Address **SPRINGFIELD MO.**

17. (a) **Burial** (b) Date thereof **Dec 15-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn Bur**

18. (a) Signature of funeral director **J.W. Lingner Co.**
(b) Address **SPRINGFIELD MO.**

19. (a) **12-15-44** (b) **B. W. Hurdley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **13**
year **1944** hour **5** minute **20 P.** M.

21. I hereby certify that I attended the deceased from **Jan 1944 to Dec 13 1944**
that I last saw him alive on **Dec 13 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Cardio-renal-vascular**
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) **131a**

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 **0**

23. Signature **May 1944** (M. D. or other) **MD**
Address **Springfield Mo** Date signed **12-15-44**

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

MOTHER FATHER

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

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.....

Max Rhodes
.....
Licensed Embalmer No. *4071*
.....
P. O. Address *Springfield*
.....
X

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.