

FILED FEB 8 1945
128

Registration District No.

Primary Registration District No. 2000

Registrar's No.

67

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: **344 W. Brower**
(If not in hospital or institution, write street number or location) **1**
(d) Length of stay: In hospital or institution **None** (Specify whether)
In this community **40 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene** **39**
(c) City or town **Springfield,**
(If outside city or town limits, write "RURAL.") **5**
(d) Street No. **344 W. Brower**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **22nd**
year **1945** hour **12:10** minute **P.** M.

21. I hereby certify that I attended the deceased from **JAN. 22**, 19**45**, to **JAN. 22**, 19**45**;
that I last saw her alive on **JAN. 22**, 19**45**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Artery - Vascular Disease**
Duration **7 yrs.**

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **131a**
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME **Calla Adeline Bennett**

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 **Widowed**

6. (b) Name of husband or wife **George W. Bennett** 6. (c) Age of husband or wife if alive **Unknown** years

7. Birth date of deceased **March 29,** **1876**
(Month) (Day) (Year)

8. AGE: Years **68** Months **9** Days **23** If less than one day hr. min.

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

10. Usual occupation **In Home**

11. Industry or business
MOTHER FATHER { 12. Name **UNK.**
13. Birthplace **UNK.** **UNK.**
(City, town, or county) (State or foreign country)
14. Maiden name **UNK.**
15. Birthplace **UNK.** **UNK.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Effie Hughey**
(b) Address **Springfield, Missouri**

17. (a) **Burial** (b) Date thereof **Jan. 26, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Green Lawn Cemetery**

18. (a) Signature of funeral director **Alma Lohmeyer** **Funeral Home**
(b) Address **Springfield, Missouri**

19. (a) **1-29-45** (b) **Dr. W. J. Handley**
(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) years of injury
23. Signature **Max Sept** (M. D. or other) **MD.**
Address **Springfield Mo** Date signed **1-29-45**

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

99266

980

44

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 L. L. Roof

Licensed Embalmer No. 3044

P. O. Address Springfield Mo

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.

X