

FILED MAY 9 1945
Registration District No. 93

Primary Registration District No. 4154

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

1. PLACE OF DEATH:

(a) County Dade

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

(c) Name of hospital or institution: City
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 55 years (Specify whether years, months or days)

In this community 55 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade 29

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

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

(e) Citizen of foreign country? (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME ADDA WILLIS KILLINGSWORTH

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F 1. Color or race W

5. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Charles C. 6. (c) Age of husband or wife if alive years

7. Birth date of deceased September 7 1869
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 3 If less than one day hr. min.

9. Birthplace Noble County Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business Home

MOTHER FATHER { 12. Name Wm P. Guiler

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

14. Maiden name Mary C. Franklin

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

16. (a) Informant Oliver Killingsworth

(b) Address Jefferson City Mo.

17. (a) Burial (b) Date thereof 3-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Home

18. (a) Signature of funeral director Sam E. Demaree

(b) Address Greenfield Mo.

19. (a) Mar 12 1945 (b) Phyllis Lack
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10
year 1945 hour 2 minute 15 P. M.

21. I hereby certify that I attended the deceased from 1-20-45
1945 to March 10 1945

that I last saw her alive on March 10 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of stomach + liver

Duration _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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

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 St. O. Cowan (M. D. or other) _____
Address Greenfield Mo. Date signed 3-10-45

1082

RECEIVED
District Health Officer No. 6,
District File Number 445-465
Date Filed APR 20 1945

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 Sam E. Senseney Jr

Licensed Embalmer No. 4099

P. O. Address Greenfield 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.