

FILED MAY 28 1945

Registration District No. 128

Primary Registration District No. 200D

Registrar's No. 385

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: Spfld. ~~Barge Hospital~~ Baptist Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Weeks
(Specify whether years, months or days) 3 Weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Route # 2 Elkland, Mo.
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country

3. (a) PRINT

FULL NAME Carolyn Pinkly

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife NONE 6. (c) Age of husband or wife if alive X X years
7. Birth date of deceased Oct. 12, 1942
(Month) (Day) (Year)

8. AGE: Years 2 Months 6 Days 17
If less than one day hr. min.

9. Birthplace Dallas County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Lorene Pinkley
15. Birthplace Charity Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant J. C. Pinkly

(b) Address Elkland, Mo. Route # 2

17. (a) Burial (b) Date thereof 5/11/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Masadonia Cemetery

18. (a) Signature of funeral director H. H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 5-10-45 (b) Dr. W. S. Haeckly
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 9
year 1945 hour 7 minute 40 P.M.
21. I hereby certify that I attended the deceased from 4-14-45
....., 19....., to 5-9- 1945
that I last saw her alive on 5-8-45, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Toxemia
Duration 1 wk

Due to Bacterial pneumonia

Due to Multiple abscesses of lung 3 wk

Due to Ulcerative pharyngitis 2 wk

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Same as above

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?.....

(Specify type of place) While at work? (a) Means of injury.....

23. Signature W. B. Beach (M. D. or other).....

Address Springfield, Mo. Date signed 5-9-45

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

29
20
6

984

4

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.

This body Not Embalmed