S. No. 2
OM—5-42
v. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 11 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18495

Registration District No. ~~128~~ 373 Primary Registration District No. 6265 Registrar's No. 36

1. PLACE OF DEATH:

(a) County ~~GREENE~~ WEBSTER

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

(c) Name of hospital or institution: R.F.D. # 3 Grant Twp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County ~~Greene~~ Webster

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

(d) Street No. R.F.D #3
(If rural, give location)

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

If yes, name country ✓

3. (a) PRINT FULL NAME IRENA A. WOMMACK

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 JOHN F. WOMMACK

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased Aug. (Month) 6 (Day) 1865 (Year)

8. AGE: Years 79 Months 9 Days 25 If less than one day ..... hr. ..... min.

9. Birthplace GREENE Co. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name Asbury Lillard Highfill
13. Birthplace ..... (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Henrietta Egell
15. Birthplace ..... (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Ernest B. Wommack
(b) Address Strafford Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Bass Chapel Cem.

18. (a) Signature of funeral director J. W. Klingner & Co.
(b) Address Springfield Mo.

19. (a) June 3, 45 (Date received local registrar) (b) Charlotte Bruce (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 31 year 1945 hour 7 minute 00 A.M.

21. I hereby certify that I attended the deceased from May 27, 1945 to May 30, 1945 that I last saw h..... alive on May 30, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Broncho Pneumonia	
Due to	
Due to	
Other conditions (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? (Specify type of place)

While at work? (e) Means of injury

23. Signature E M Bailey (M. D. or other)

Address Elkland Mo Date signed

1200

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 645-662
Date Filed JUN 17 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 Ogle Stone Jr.

Licensed Embalmer No. 4176

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.