

FILED AUG 13 1945

Registration District No. _____

Primary Registration District No. 2000

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

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: St. John's Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 Days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Anna C. Dent

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 Married
6. (b) Name of husband or wife George W. Dent 6. (c) Age of husband or wife if alive UNK years
7. Birth date of deceased Dec. 9, 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 15 If less than one day hr. min.

9. Birthplace Smadjabachen Sweden
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Leonard Danilson
13. Birthplace UNK Sweden
(City, town, or county) (State or foreign country)
14. Maiden name Mary Stahl
15. Birthplace UNK Sweden
(City, town, or county) (State or foreign country)

16. (a) Informant George W. Dent
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 7-28-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

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

(b) Address Springfield, Mo.

19. (a) 7-26-45 (b) S.W. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 354 Hovey
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1945 hour 2 minute 30a.M.

21. I hereby certify that I attended the deceased from July 1st 1945
to July 24, 1945
that I last saw him alive on July 23, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Duration 24 Days

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? _____

While at work? _____ (Specify type of place)
(a) _____ (b) _____ (c) _____
(Specify type of place) (a) _____ (b) _____ (c) _____

23. Signature Handley (M. D. or other) MD.
Address Springfield Mo. Date signed 7-26-45

MAR 13 1981

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 Walter E. Hamill
Licensed Embalmer No. 3818
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.