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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 12 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27438

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 676

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: 662 E. Madison 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 75 Yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 29

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

(d) Street No. 662 East Madison 1
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Fanny J. White

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 1

6. (b) Name of husband or wife A. C. White

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased April (Month) 9 (Day) 1870 (Year)

8. AGE: Years 75 Months 4 Days 17 If less than one day ..... hr. ..... min.

9. Birthplace Greene Co. (City, town, or county) Missouri 1 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Housewife

FATHER
12. Name B. J. Gott
13. Birthplace UNK. (City, town, or county) Tenn. 1 (State or foreign country)

MOTHER
14. Maiden name Amanda C. McCaslin
15. Birthplace UNK. (City, town, or county) Missouri 1 (State or foreign country)

16. (a) Informant Mrs. B. E. Sneed
(b) Address Greenfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-45 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn

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

19. (a) 8-28-45 (Date received local registrar) (b) Dr W E Hardy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 26
year 1945 hour ..... minute 7:00A.M.

21. I hereby certify that I attended the deceased from 8/20 1945, to 8/26 1945
that I last saw her alive on 8/20 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Thrombosis	1 hour
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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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 [signature] (M. D. or other)
Address Springfield, Mo. Date signed 8/27/45

984 (Licensed Embalmer's Statement on Reverse Side)

DEC 13 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 Max Rhodes

Licensed Embalmer No. 4071

P. O. Address Springfield

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.