

FILED OCT 9 1945 **STANDARD CERTIFICATE OF DEATH**

State File No. _____
Registrar's No. 754

Registration District No. 128 Primary Registration District No. 5466

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

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Rural, S. Campbell Twp.
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 6 da. (Specify whether years, months or days)

In this community 7 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene

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

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

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Millie Breon

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 22 year 1945 hour 8 minute 15 P. M.

21. I hereby certify that I attended the deceased from 9/16/45 to 9/22/45 and that death occurred on the date and hour stated above.

(that I last saw h. or w. alive on 9-22-45 19. _____)

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased March 9, 1888
(Month) (Day) (Year)

Immediate cause of death Crowning Thrombosis

Duration _____

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>57</u>	<u>6</u>	<u>13</u>	hr. _____ min. _____

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 5 months of death)

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

10. Usual occupation House wife

Major findings: No autopsy

Of operations No

Of autopsy No

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

MOTHER FATHER

11. Industry or business _____

12. Name A. L. Bready

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

14. Maiden name Unknown

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

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? _____ (f) Means of injury _____

23. Signature G. R. Schultz (M.D. or other) _____
Address Fordland Mo. Date signed 9/27/45

16. (a) Informant Elna Breon

(b) Address Fordland Mo.

17. (a) Burial (b) Date thereof 9-25-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fordland - Mo. Cem.

18. (a) Signature of funeral director Fred C. Pheme

(b) Address Springfield Mo.

19. (a) 9-24-45 (b) F. W. Haudley
(Date received local registrar) (Registrar's Signature)

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.....

Fred C. Thieme

Licensed Embalmer No. *2899*

P. O. Address.....

Springfield, Mo
X

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.