

FILED OCT 8 1945

STANDARD CERTIFICATE OF DEATH

State File No. 30564

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 740

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 10 days
In this community 10 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas / 07
(c) City or town Cabool
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME HENRY HANEBRINK

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

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

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

7. Birth date of deceased February 3, 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 13 If less than one day hr. min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Chris Hanebrink

13. Birthplace UNK. Germany /
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Morfield

15. Birthplace UNK. Germany /
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph A. Hanebrink

(b) Address Cabool, Missouri

17. (a) Burial (b) Date thereof 9-18-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cabool, Missouri

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address 534 St. Louis St., Springfield, Mo.

19. (a) 9-18-45 (b) W. H. Hurdley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 16,
year 1945 hour 4 minute 15 P.M.

21. I hereby certify that I attended the deceased from 9/5/45 19. to 9/16/45 19. and that I last saw him im alive on 9/16/45 19. and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial disease Duration 6 mo

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy 93e!

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 J. B. Lemmon (M. D. or other) M.D.

Address Springfield, Mo. Date signed 9/18/45

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

984

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OCT 10 1965

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed

Lewis G. Scharpf

Licensed Embalmer No.

3802

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.