

FORM-2-43  
Rev. 5-17-39  
K35697

**FILED** NOV 6 1945  
Registration District No. 2

Primary Registration District No. 4154

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
 (a) County Dade  
 (b) City or town Greenfield  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: City 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)  
 In this community 40 years

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Dade  
 (c) City or town Greenfield  
(If outside city or town limits, write "RURAL")  
 (d) Street No. City 1  
(If rural, give location)  
 (e) Citizen of foreign country? — (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** ELLA GIVEN  
 3. (b) If veteran, name war No  
 3. (c) Social Security No. No

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month October day 30  
 year 1945 hour 9 minute 30 A.M.

4. Sex F 5. Color or race W  
 6. (a) Single, widowed, married, divorced WIDOWED  
 6. (c) Age of husband or wife if alive — years  
 7. Birth date of deceased July 9 1869  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 19 1945 to Oct 30 1945  
 that I last saw her alive on Oct 30 1945  
 and that death occurred on the date and hour stated above.

8. AGE: Years 76 Months 3 Days 21  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Myocarditis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

Other conditions 932  
(Include pregnancy within 3 months of death)

10. Usual occupation Home

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

11. Industry or business Home

**MOTHER FATHER**  
 12. Name No Record  
 13. Birthplace No Record 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name No Record  
 15. Birthplace No Record 9  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Harry A. Given  
 (b) Address Omaha, Nebraska

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof 10-31-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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)

18. (a) Signature of funeral director John B. Sweeney  
 (b) Address Greenfield, Mo.

While at work? \_\_\_\_\_  
(Specify type of place) (Means of injury)

19. (a) Nov 5 1945 (b) Geo L. West  
(Date received local register) (Registrar's signature)

23. Signature Herchel Blackney or other DO  
 Address Greenfield Date signed 11-2-45

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

**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 Sam E. Sencerney Jr.  
Licensed Embalmer No. 4099  
P. O. Address Greenfield, 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.**