

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

FILED NOV 13 1945
228

Registration District No.

Primary Registration District No. 2000

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:
1086 S. Florence Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 40 Years
(Specify whether years, months or days)
In this community. 40 Years

3. (a) PRINT FULL NAME MARY EDNA AGNEW

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife William Agnew 6. (c) Age of husband or wife if alive DNK years
7. Birth date of deceased January 16, 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 9 11 hr. min.

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

10. Usual occupation Home

11. Industry or business None

12. Name Alfred Hildebran
13. Birthplace White County Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Caroline Jones
15. Birthplace Unknown Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Hazel Agnew
(b) Address 1086 S. Florence, Spfd., Mo.

17. (a) Burial (b) Date thereof Oct. 30, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood

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

(b) Address Springfield, Missouri

19. (a) 10-29-45 (b) [Signature]
(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. 1086 S. Florence Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 27th
year 1945 hour 11:10 minute AM M.

21. I hereby certify that I attended the deceased from 10-28-35
to 10-27, 1945, to 10-5, 1945
that I last saw QB alive on 10-5
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Insufficiency 3 mo
Due to Hypertensive Heart Disease 10 yr

Due to Other conditions 0
(Include pregnancy within 3 months of death)

Major findings: Of operations 0
Of autopsy 0
PHYSICIAN [Signature]
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) 0
(b) Date of occurrence 0
(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) (b) Means of injury

23. Signature [Signature] (M. D. or other)
Address 207 Midway Bldg Date signed 10/29/45

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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.....

Fred C. Thieme

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Fred C. Thieme

Licensed Embalmer No. 2899

P. O. Address. Springfield, Missouri

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.

X