

FILED DEC 21 1945

Registration District No. 69

Primary Registration District No. 4122

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Christian
 (b) City or town Nixa
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 weeks
 In this community 2 weeks
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stone
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. R#2, Galena
 (If rural, give location)
 (e) Citizen of foreign country? no
 If yes, name country

3. (a) PRINT FULL NAME Henry Green Estes

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

4. Sex male 5. Color or race white
 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Sarah Estes
 6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased Jan. 29, 1860
 (Month) (Day) (Year)

8. AGE: Years 85 Months 9 Days 26
 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name Milton H. Estes

13. Birthplace unknown

14. Maiden name Mary Adams (State or foreign country)

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

16. (a) Informant Mrs. Robert Rice

(b) Address Nixa, Mo.

17. (a) burial (b) Date thereof Nov. 28, 45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Selmore cem.

18. (a) Signature of funeral director T.W. Maples

(b) Address Clever, Mo.

19. (a) Nov. 28, 1945 (b) Mrs. Alline Dreier
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 25
 year 1945 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from Nov. 11, 1945, to Nov. 25, 1945,
 that I last saw him alive on Nov. 25 - 8:00 P.M., 1945,
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
 Due to Nephritis 2 or 3 years

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

Major findings: Of operations
 Of autopsy
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, specify:
 (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?

While at work? (Specify type of place) (e) Means of injury
 23. Signature H. B. Hanson (M. D. or other)
 Address Nixa, Mo. Date signed 11/26/45

Duration 2 years
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6;

District File Number 1245-1162

Date Filed 12-17-45

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

J. W. Maples

Licensed Embalmer No. 2985

P. O. Address Clever, 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. 1

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3880

State File No. Jan
Registrar's No. 9

Registration District No. 69

Primary Registration District No. 4122

1. PLACE OF DEATH: Christian
 (a) County.....
 (b) City or town..... nixa
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community.....
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State..... (b) County.....
 (c) City or town.....
 (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: Henry G. Estes
 3. (b) If veteran, name war.....
 3. (c) Social Security No.....

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month.....
 year..... hour..... minute..... M.
 21. I hereby certify that I attended the deceased from.....
 to....., 19.....
 that I last saw him..... alive on....., 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

4. Sex m
 5. Color or race w
 6. (a) Single, widowed, married, divorced.....
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive..... years

Duration
 acute nephritis, but
 do not know cause
 Due to.....
 Due to.....

7. Birth date of deceased: Jan 29
 (Month) (Day) (Year)
 8. AGE: Years 85 Months 9 Days 14
 If less than one day..... hr. min.

9. Birthplace.....
 (City, town, or county) (State or foreign country)
 10. Usual occupation.....
 11. Industry or business.....

Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations.....
 Of autopsy.....
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name.....
 13. Birthplace.....
 (City, town, or county) (State or foreign country)
 14. Maiden name.....
 15. Birthplace.....
 (City, town, or county) (State or foreign country)
 16. (a) Informant.....
 (b) Address.....
 17. (a)..... (b) Date thereof.....
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation.....
 18. (a) Signature of funeral director.....
 (b) Address.....
 19. (a)..... (b).....
 (Date received local registrar) (Registrar's signature)

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?
 While at work?..... (Specify type of place)
 (e) Means of injury.....
 23. Signature..... (M. D. or other).....
 Address..... Date signed.....

SUPPLEMENTARY

READING BLACK INK—MAKE A PERMANENT RECORD

40902