

FILED JAN 11 1946

Registration District No. **141**

Primary Registration District No. **3025**

Registrar's No. **133**

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

1. PLACE OF DEATH:

(a) County **Howell**

(b) City or town **West Plains**
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution..... (Specify whether
In this community **19 years**..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri**..... (b) County **Howell** **46**

(c) City or town **West Plains**
(If outside city or town limits, write "RURAL")

(d) Street No. **919 Worcester**
(If rural, give location)

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

3. (a) PRINT FULL NAME **DESSIE CARLTON RENFROW**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **25**,
year **1945** hour **12**: minute **30** P. M.

21. I hereby certify that I attended the deceased from
12-22-1945 to **12-25-1945**
that I last saw ~~her~~ **her** alive on **12-25**, 1945,
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife **Virgil P. Renfrow** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **June 23, 1877**
(Month) (Day) (Year)

Immediate cause of death
Coronary Thrombosis

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

Duration

3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

8. AGE: Years Months Days If less than one day

68 **6** **2** hr. min.

9. Birthplace **Des Moines, Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business

MOTHER FATHER

12. Name **Sutton**

13. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Julia Renfrow**
(b) Address **West Plains, Mo.**

17. (a) **Burial** (b) Date thereof **DEC. 27, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
Oak Lawn Cem.
(c) Place: burial or cremation **West Plains, Mo.**

18. (a) Signature of funeral director **Hal Flourburgh**
(b) Address **West Plains, Mo.**

19. (a) **Dec. 30, 1945** (b) **Madysa Harrison**
(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 **9 m**

23. Signature **E. C. Bohrer** (M. D. or other) **m d**
Address **West Plains, Mo.** Date signed **12-27-45**

RECEIVED

District Health Officer No. 5,

District File Number 14670
Date Filed 1.9.46

Jan 8 1946

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 Hal Thourburgh

Licensed Embalmer No. 3408

P. O. Address West Plains, 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.