

FILED JAN 26 1946
128

State File No. _____

Registration District No. _____

Primary Registration District No. 2000

Registrar's No. 15

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:
SPRINGFIELD Baptist Hosp. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution... 3 Days
(Specify whether years, months or days)
In this community... 3 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State... Missouri (b) County... Shannon 101
(c) City or town... Terresita 0
(If outside city or town limits, write "RURAL")
(d) Street No... 0
(If rural, give location)
(e) Citizen of foreign country?... (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Estel Renegar

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

4. Sex... Male 6
5. Color or race... White
6. (a) Single, widowed, married, divorced... Single
6. (b) Name of husband or wife... None
6. (c) Age of husband or wife if alive... XX years
7. Birth date of deceased... APR. 9 - 1911
(Month) (Day) (Year)

8. AGE: Years 34 Months 8 Days 26
If less than one day hr. min.

9. Birthplace... SHANNON Co. MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation... FARMER

11. Industry or business _____

MOTHER FATHER
12. Name... MARION Renegar
13. Birthplace... UNK. MISSOURI
(City, town, or county) (State or foreign country)
14. Maiden name... ADAK SMOOTHERMAN
15. Birthplace... UNK. Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant... OMER Renegar
(b) Address... Terresita, MO

17. (a) Removal... (b) Date thereof... 1/6/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation... Terresita MO

18. (a) Signature of funeral director... H.H. Lohmeyer
(b) Address... Springfield, MO

19. (a) 1-7-46 (b) 8 W E Haudley
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month... Jan. day 5
year... 1946 hour 2 minute 05 P. M.

21. I hereby certify that I attended the deceased from Jan 2 to Jan 5, 1946
that I last saw him alive on Jan 5, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death... Pneumonia
Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in (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) _____
(Specify type of place) (Cause of injury) _____

23. Signature... J. L. Smith (M. D. or other) _____
Address... Springfield MO Date signed 1-7-46

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 *L. A. Gorman*

Licensed Embalmer No. *3177*

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.

X

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb
Registrar's No. 15

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Estel Renegar
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased Apr 9 (Month) (Day) (Year)

8. AGE: Years 34 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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)

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 _____

MEDICAL CERTIFICATE FROM
20. DATE OF DEATH: Month _____ Year 1946 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 _____

Due to Chronic nephritis
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, 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 _____

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

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

SUPPLEMENTARY

2752