

FILED JAN 26 1946

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: Burge Hospital ( )  
(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.....

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39

(c) City or town Springfield 2  
(If outside city or town limits, write "RURAL.")

(d) Street No. 1407 N. Broadway 6  
(If rural, give location)

(e) Citizen of foreign country? no 0  
(Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Annie E. Welhener

3. (b) If veteran, name war None

3. (c) Social Security No. UNK

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 9  
year 1946 hour 4 minute 50 P.M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife UNK 6. (c) Age of husband or wife if alive Yes years

7. Birth date of deceased June 21, 1885  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-9-46, 19... to 1-9-46, 19...  
that I last saw h. UNK alive on 1-9-46, 19...  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
✓	60	6	18	hr. min.

Immediate cause of death Coronary Occlusion Duration 12 hrs.

Due to Hypertensive Heart Disease 1-2 yrs.

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

10. Usual occupation Manager Tent & Awning Co.

Due to .....

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

11. Industry or business Tent and Awning

12. Name Wilson A. Peters

13. Birthplace Allenton Pa.  
(City, town, or county) (State or foreign country)

14. Maiden name Mollie Ferguson

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

Major findings: 940  
Of operations.....  
Of autopsy.....

PHYSICIAN: \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Billie Douglas

(b) Address Springfield, Mo.

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 1-12-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cem.

18. (a) Signature of funeral director [Signature]

(b) Address Springfield Mo.

19. (a) 1-11-46 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

(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 [Signature] (M. D. or other).....  
Address Springfield, Mo. Date signed 1-10-46

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

687

**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 Ogle Stone Jr  
Licensed Embalmer No. 4196  
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