

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Carthage  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Dodson Rest Home 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: in hospital or institution 13 months  
(Specify whether years, months or days)  
In this community 60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 4  
(c) City or town Carthage  
(If outside city or town limits, write "RURAL")  
(d) Street No. 408 E. Third St.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Florence Fennimore

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 widowed  
6. (b) Name of husband or wife A. Fennimore  
6. (c) Age of husband or wife if alive ---- years  
7. Birth date of deceased: June 4 1861  
(Month) (Day) (Year)

8. AGE: Years 84 Months 7 Days 7  
If less than one day hr. min.

9. Birthplace Peru Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business ----

MOTHER FATHER { 12. Name Annon James  
13. Birthplace unknown Indiana  
(City, town, or county) (State or foreign country)  
14. Maiden name Phoebe Reel  
15. Birthplace unknown Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Pearl Hole  
(b) Address E. 3rd St. Carthage

17. (a) burial (b) Date thereof Jan 14, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fullerton, Cemetery

18. (a) Signature of funeral director Knell Mortuary  
(b) Address Carthage, Mo.

19. (a) 1-14-46 (b) P. B. Clinton  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 11  
year 1946 hour 12:20 minute 8 M.

21. I hereby certify that I attended the deceased from Did Not attend  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac Failure  
Chronic Respirator  
Senile Atrophy  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions: -----  
(Include pregnancy within 3 months of death)

Major findings: 1316 Coroner's Investigation  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, 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) (g) Means of injury

23. Signature A. W. [unclear] (M. D. or other) do  
Address 211 [unclear] Date signed 1/13/46

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

1381

46-1-34

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 Emm. L. Jones

Licensed Embalmer No. 391

P. O. Address Carters

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.