

FILED MAY 13 1946

Registration District No. 122

Primary Registration District No. 5457

Registrar's No. 9

1. PLACE OF DEATH  
 (a) County Franklin - Pond Creek  
 (b) City or town rural  
(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 years, months or days)  
 In this community all of life

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County Green 39  
 (c) City or town rural  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Billings R#2  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country.....

3. (a) PRINT FULL NAME Mrs. Mary M. Laney  
 3. (b) If veteran, name war none  
 3. (c) Social Security No. none

MEDICAL CERTIFICATION  
 20. DATE OF DEATH, Month Apr. day 6  
1946 year. hour 9 minute 20 A.M.

4. Sex Female 5. Color or race white  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Frank Laney  
 6. (c) Age of husband or wife if alive 62 years  
 7. Birth date of deceased March 3, 1891  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 10 1945  
 19..... to April 4 1946;  
 that I last saw him EH alive on April 4 1946;  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>1</u>	<u>3</u>	<u>Mo</u> hr. min.

Immediate cause of death Coronary Heart Disease  
 Duration 1 week

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

Due to Essential Hypertension  
 Due to.....

10. Usual occupation housewife

Other conditions Varicose ulcers  
(Include pregnancy within 3 months of death)

11. Industry or business.....  
 12. Name B.R. Newton  
 13. Birthplace Ill.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Sarah Ann Glosson  
 15. Birthplace unknown  
(City, town, or county) (State or foreign country)

Major findings:  
 Of operations.....  
 Of autopsy (27)  
 PHYSICIAN.....  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Roxie Snodgrass  
 (b) Address Republic, Mo.

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof April 9 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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?  
(Specify type of place)  
 While at work?..... (e) Means of injury 0

(c) Place: burial or cremation Wades Chapel  
 18. (a) Signature of funeral director T.W. Maples  
 (b) Address Clever, Mo.

23. Signature James P. Kilgus M.D. or other MO  
 Address ..... Mo. Date signed 4/11/46

19. (a) April 9 1946 (b) J. Florence Bostan  
(Date received local registrar) (Registrar's signature)

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

RECEIVED

Greene County Health Office,

County File Number 46-5-62

Date Filed 5-10-46

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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. Maple

Licensed Embalmer No. 2985

P. O. Address Cleveland 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.