

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

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:
334 W. Central (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 App: 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No. 334 West Central 6
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No) 0
If yes, name country.....

3. (a) PRINT FULL NAME NANCY ELIZABETH MOONEY

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

4. Sex female / 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Jacob P. Mooney
6. (c) Age of husband or wife if alive 1878 years
7. Birth date of deceased November 2, 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 11 23 ..hr. ..min.

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

10. Usual occupation Domestic

11. Industry or business.....
12. Name Wm. Johnson
13. Birthplace Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name Julia Jones
15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 25
year 1946 hour 4 A.M. minute..... M.

21. I hereby certify that I attended the deceased from
JAN 1944 to 10-19 1946;
that I last saw her alive on 10-18 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration
CEREBRAL HEMORRHAGE 5 MIN.
Due to ARTERIO SCLEROSIS (HYPERTENSION) 6 YR.

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

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

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..... 2

23. Signature Howard J. Mason (M. D. or other) MD.
Address 606 E. Sunshine Date signed 10-28-46

(Licensed Embalmer's Statement on Reverse Side) Springfield Mo.

MOTHER FATHER

mean
22-1

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..... *E. A. Ruff*.....
Licensed Embalmer No..... 3044.....
P. O. Address..... Springfield, Missouri.....

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.

