

FILED DEC 17 1946

Registration District No. _____

Primary Registration District No. **2000**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Springfield 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 **1 week**
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME **William Jomp. Hankins**
 3. (b) If veteran, name war **None**
 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of ~~husband~~ wife **Erca**
 6. (c) Age of ~~husband~~ or wife if alive **56** years
 7. Birth date of deceased **Dec 3 1886**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 - 4 hr. min.

9. -Birthplace **Everton Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business

MOTHER FATHER
 12. Name **Joseph Hankins**
 13. Birthplace **Everton Mo.**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Dorothy Sutter**
 15. Birthplace **Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Joe W. Hankins**
 (b) Address **Everton Mo.**
 17. (a) **5 in Big Creek** (b) Date thereof **12-9-46**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Big Creek, Everton Mo.**

18. (a) Signature of funeral director **W. C. Handley**
 (b) Address **Rush Grove Mo.**
 19. (a) **1-10-47** (b) **W. C. Handley**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **7** ch
 year **1946** hour **3** minute **38** M.

21. I hereby certify that I attended the deceased from _____, 19____, to **12-7-1946**
 that I last saw him alive on **12-7-1946**
 and that death occurred on the date and hour stated above.

Immediate cause of death
Coronary thrombosis
Cerebral apoplexy
 Due to **Arteriosclerosis**

Duration
21 days
7 days

Other conditions: **Bronchopneumonia**
 (Include pregnancy within 3 months of death) **5 days**

PHYSICIAN

Major findings:
 Of operations _____
 Of autopsy **gcp**
 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 **0**
 Signature **W. C. Handley** (M. D. or other) **M. D.**
 Address **Med Arts Bldg. Springfield** Date signed **12-7-46**

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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 Maudie O Morris
Licensed Embalmer No. 12,053
P. O. Address Cash Creek, W.

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.

Registration District No. 128

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) (Specify whether

3. (a) PRINT FULL NAME

William J. Hanken

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 M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Dec 3 (Month) (Day) (Year)

8. AGE: Years 60 Months _____ Days _____ If less than one day _____ 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-10-47 (Date received local registrar) (b) W E Handley (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 CERTIFICATION

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 _____

Duration

Due to _____

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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

40226