

No. 2
12-45
17-39
X47070

State File No. 794
Registrar's No. 36

FILED JAN 22 1947

Registration District No. 128

Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County Greene
Springfield

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1915 N. Rogers 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 years (Specify whether years, months or days)

In this community 5 years (Specify whether years, months or days)

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") ⁶

(d) Street No. 1915 N. Rogers Ave., ⁰
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Clifford Leon Hannum

3. (b) If veteran, name war None

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 12
year 1947 hour 8 minute 15 A. M.

4. Sex Male 0

5. Color or race White 1

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

6. (b) Name of husband or wife Bertha Mae Hannum

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased October 10 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 11 1947 to Jan 12 1947
that I last saw him alive on Jan 11 1947
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>3</u>	<u>2</u>	hr. min.

Immediate cause of death Chronic myocarditis (?)

Duration (?)

Due to _____

Due to _____

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

10. Usual occupation Retired Floral Shop Opera

11. Industry or business Floral Shop

Underlying conditions Bronchial asthma
(Include pregnancy within 3 months of death)

MOTHER FATHER

12. Name James Hannum

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

14. Maiden name Sarah E. Johnson

15. Birthplace unk. pa.
(City, town, or county) (State or foreign country)

Major findings: _____

Of operations _____

Of autopsy 930

PHYSICIAN _____

Underline the cause to which death should be charged statistically. ✓

16. (a) Informant Springfield Mo.

(b) Address Burial

17. (a) (Burial, cremation, or removal) East Lawn Cem.

(b) Date thereof 1-16-1947
(Month) (Day) (Year)

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? _____

18. (a) Signature of funeral director J. W. Klingner & Co.

(b) Address Springfield Mo.

19. (a) Jan. 15, 1947 (Date received local registrar)

(b) W. S. Handley M.D. (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury 0

23. Signature James A. Bryan M.D.

Address 930 1/2 Commercial Springfield Mo.

Date signed 1/13/47

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. G. Stone Jr.

Licensed Embalmer No. *4176*

P. O. Address *Springfield*

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.