

No. 2
12-45
17-39
X47070

FILED FEB 14 1947
Registration District No. 2000

Primary Registration District No. 2000

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:
Howell Rest Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Year
10 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Earnest L. Karnaghon

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct. ? 1885
(Month) (Day) (Year)

8. AGE: Years 62 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Joseph Karnaghon

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

14. Maiden name Unknown

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

16. (a) Informant Vernon Karnaghon

(b) Address Memphis, Tenn.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 2/6/47
(Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 2/9/47 (Date received local registrar)

(b) W.E. Hardley (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield
(If outside city or town limits, write "RURAL")

(d) Street No. 457 Cherry
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 3 year 1947 hour 9 minute 0 M.

21. I hereby certify that I attended the deceased from 6:30 PM 2-3-47 to 2-3-47 1947

that I last saw him alive on 2-3-47 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac insufficiency years

Duration _____

Due to T

Due to T

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 95

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)

(c) Means of injury _____

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

Address 432 Med. Bldg. Springfield, Mo. Date signed 2-9-47

APR 22 1947

APR 30 1947

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 *Walter E. Hameller*

Licensed Embalmer No. *3808*

P.O. Address *Springfield Ma.*

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 Registrar's No. 100

1. PLACE OF DEATH:
 (a) County Shelby
 (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
 3. (a) PRINT FULL NAME Earnest L Karnofka
 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 unk
 6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive unk years
 7. Birth date of deceased Oct 2 (Month) 1889 (Day) 1889 (Year)

8. AGE: Years 62 Months _____ Days _____ If less than one day _____ hr. _____ min.
 9. Birthplace Leuc (City, town, or county) (State or foreign country)

10. Usual occupation _____
 11. Industry or business _____
 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) 2-17-47 (b) W. E. Handley M.D.
 (Date received local registrar) (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 _____ Day _____
 year 1947 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

S-806