

No. 2  
12-45  
17-39  
X47070

FILED JUN 3 1947  
Registration District No. **26**

Primary Registration District No. **5463**

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

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Strafford  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
R. F. D. # 3.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. \_\_\_\_\_  
(Specify whether  
In this community 66 years 11 mo. 20 days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene  
(c) City or town Strafford  
(If outside city or town limits, write "RURAL")  
(d) Street No. R. F. D. # 3. (H. Jackson)  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Rosa E. Highfill  
3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Ben M. Highfill  
6. (c) Age of husband or wife if alive 85 years  
7. Birth date of deceased May 8, 1880  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>11</u>	<u>20</u>	hr. min.

9. Birthplace Greene Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business At Home

MOTHER FATHER { 12. Name James K. Yarbrough  
13. Birthplace N. Car.  
(City, town, or county) (State or foreign country)  
14. Maiden name Polly A. Bass  
15. Birthplace Greene Co., Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Omer Owen  
(b) Address Strafford Mo., R # 3.  
17. (a) Burial (b) Date thereof 4-30-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bass Chapel Cem.

18. (a) Signature of funeral director J. W. Klingner & Co.  
(b) Address Springfield Mo.  
19. (a) Apr 30 1947 (b) Mrs. Porter O. Wall  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28,  
year 1947 hour 2 minute 00 P. M.  
21. I hereby certify that I attended the deceased from 3/19, 1947, to 4/19, 1947  
that I last saw her alive on 4/19, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 5 days  
Due to \_\_\_\_\_

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

Major findings: Of operations 107  
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 R. H. Felt (M. D. or other) \_\_\_\_\_  
Address Strafford Mo. Date signed 4/30/47

RECEIVED

Greene County Health Office,

County File Number 47-6-59

Date Filed 6-2-47

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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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.**