

3. No. 2
-12-45
5-17-39
I X47070

STATE OF MISSOURI
BUREAU OF THE CENSUS
FILED JUL 12 1947

STANDARD CERTIFICATE OF DEATH

State File No. **20655**
Registrar's No. _____

Registration District No. **123** Primary Registration District No. **5462**

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:
R. F. D. # 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 37 Years,
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Greene **39**
(c) City or town Springfield **0**
(If outside city or town limits, write "RURAL")
(d) Street No. R. F. D. # 10 **0**
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME Flora Elizabeth Harry
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 Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased January 8, 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 5 11 hr. min.

9. Birthplace Logansport Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business At Home

MOTHER FATHER
12. Name Joseph Wright
13. Birthplace Unknown **9**
(City, town, or county) (State or foreign country)
14. Maiden name Martha Reid
15. Birthplace Unknown **9**
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Zelma Campbell

(b) Address Springfield Mo. R # 10

17. (a) Burial (b) Date thereof 6/21/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Comfort Cem.

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

(b) Address Springfield Mo.

19. (a) June 23, 1946 (b) Mrs Porter O'Kell
(Date received local registrar) (Registrar's signature) **159**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19th
year 1947 hour 6: minute 00 A. M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations 9
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? **0**

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature No physician in attendance (M. D. or other)
Address Mrs. Porter O'Kell signed (Registrar)

Fair Grove, Mo

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

RECEIVED

Greene County Health Office,

County File Number 42-7-64

Date Filed 7-11-47

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

May Rhodes

Licensed Embalmer No

4071

P. O. Address

Spring Hill

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.