

No. 2
-12-45
5-17-39
PI X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20658**

FILED JUL 12 1947
Registration District No. **122**

Primary Registration District No. **5463**

Registrar's No. _____

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. # 2 / 1st Jackson Laundry
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **62 Years** 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 # 2**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Ira Edward Highfill.**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **No.**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Maud Highfill**
6. (c) Age of husband or wife if alive **59** years
7. Birth date of deceased **October 21 1884**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 **8** **3** hr. min.

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

10. Usual occupation **Farming**

11. Industry or business **Farmer**

MOTHER FATHER {
12. Name **Benny Highfill Tenn.**
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name **Emiline Wommack Mo.**
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Maud Highfill**

(b) Address **Strafford Mo. R. # 2**

17. (a) Burial (b) Date thereof **6-27-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cedar Bluff Cem.**

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

(b) Address **Springfield Mo.**

19. (a) **6-27-47** (b) **Mrs. Pater O'Dell**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **24**
year **1947** hour **7** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **June 24** 19**47**
that I last saw him alive on **June 1** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion** Duration **10 min**

Due to **Cardio-renal vascular disease**

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) (Means of injury)

23. Signatures **Mrs. Pater O'Dell** (M. D. or other) **M.D.**
Address **Springfield Mo.** Date signed **6-25-47**

RECEIVED

Greene County Health Office;

County File Number 47-7-65

Date Filed 7-11-47

JUL 16 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 J. B. Klingner

Licensed Embalmer No. 3358

P. O. Address Springfield Mo.

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.