

FILED OCT 6 1947

Registration District No. 158

Primary Registration District No. 2000

Registrar's No. 830

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:
2211 N. Kansas Ave.,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 14 Yr. 10 Mo. 25 Days (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")
(d) Street No. 2211 N. Kansas Ave., 6
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sep. day 19
year 1947 hour 7 minute 05 A.M.
21. I hereby certify that I attended the deceased from Apr, 1947, to Sept 19, 1947;
that I last saw he alive on Sept 12, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Syncope - Following (Retro-Peritoneal)
Duration 1 yr.

Due to _____
Due to _____
Other conditions 4/6
(Include pregnancy within 3 months of death)

Major findings:
Of operations Cerebrum - Low degeneration
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? U
While at work? _____ (Specify type of place) _____ (e) Means of injury _____
23. Signature Max T. [illegible] (M. D. or other) MD
Address Springfield Mo Date signed 9-20-47

3. (a) PRINT FULL NAME Patricia Joan Cantrell
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 Single

6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 24, 1932
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>14</u>	<u>10</u>	<u>25</u>	_____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business Child in School

12. Name Barney Cantrell

13. Birthplace Webster Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Ollie Clayton,

15. Birthplace Webster Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Barney Cantrell
(b) Address Springfield Mo.

17. (a) Burial (b) Date thereof 9-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director J. W. Klingner
(b) Address Springfield Mo.
19. (a) 9-22-47 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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 Ogle 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.