No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

851

State File No.

FILED FEB 9 1948

Registration District No. 320 | Primary Registration District No. 5459 | Registrar's No.

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Rural Center Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Route # 4 Springfield, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 89 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Greene
(c) City or town: Rural Center Township
(If outside city or town limits, write "RURAL")
(d) Street No.: Route # 4 Springfield, Mo.
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Elizabeth A. Kindrick
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Wm. J. Kindrick
6. (c) Age of husband or wife if alive: Dec. years
7. Birth date of deceased: Sept. (Month) 3 (Day) 1855 (Year)

8. AGE: Years 92 | Months 4 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace: (Near) Stillwater (City, town, or county) Tenn. (State or foreign country)
10. Usual occupation: Home
11. Industry or business:
MOTHER FATHER
12. Name: Samuel Wilson
13. Birthplace: (City, town, or county) Tenn. (State or foreign country)
14. Maiden name: Stella Richesin
15. Birthplace: (City, town, or county) Tenn. (State or foreign country)
16. (a) Informant: May Kindrick
(b) Address: Rt # 4 Springfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/10/48 (Month) (Day) (Year)
(c) Place: burial or cremation: Brookline, Mo.
18. (a) Signature of funeral director: H.H. Lohmeyer
(b) Address: Springfield, Mo.
19. (a) Jan 12-1948 (Date received local registrar) (b) Jewell Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 8 year 1948 hour 7 minute a. M.
21. I hereby certify that I attended the deceased from Jan 1- 1948 to Jan 8 1948 that I last saw her alive on Jan 7- 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	3 yr
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause of 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? (Specify type of place) ()
While at work? (e) Means of injury
23. Signature: E. M. LeCompte (M. D. or other) M.D.
Address: Brookline, Mo. Date signed: Jan 9-1948

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Greene County Health Office
County File Number 48-2-17
Date Filed 2-6-48

MAR 31

DEC 22 1950

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 Hamilton

Licensed Embalmer No. 3808

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.