

No. 2
-2.43
-17-39
X35697

FILED MAR 15 1948

Registration District No. **128**

Primary Registration District No. **2000**

1. PLACE OF DEATH: **GREENE**
 (a) County **Springfield**
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Burge Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **6 days**
 (Specify whether _____)
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **mo.** (b) County **Webster**
 (c) City or town **Elkland "Rural"**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **Rural**
 (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Audra Alice McDaniel**
 3. (b) If veteran, name war **None**
 3. (c) Social Security No. **None**

4. Sex **F** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Andrew**
 6. (c) Age of husband or wife if alive **59** years
 7. Birth date of deceased **Sept. 19 1884**
 (Month) (Day) (Year)

8. AGE: Years **62** Months **4** Days **26**
 If less than one day hr. _____ min. _____

9. Birthplace **Charity mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Edward Cline**
 13. Birthplace **not known Tenn.**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Hena Stever**
 15. Birthplace **Elkland mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Rosa Overall**
 (b) Address **Charity, mo.**

17. (a) **Burial** (b) Date thereof **2-18-48**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Bethany**

18. (a) Signature of funeral director **L.B. Jones**
 (b) Address **Buffalo mo.**

19. (a) **2-16-48** (b) **W.E. Handley**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **16th**
 year **1948** hour **7** minute **30 A.M.**
 21. I hereby certify that I attended the deceased from **Feb. 10 1948** to **Feb. 16 1948**
 that I last saw him alive on **Feb. 15 1948**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Cardiac failure**
 Due to **Cancer of stomach**
 Due to **Gastric hemorrhage**

Other conditions: _____
 (Include pregnancy within 3 months of death)
 Major findings: **U.B.**
 Of operations: _____
 Of autopsy: _____

Duration _____
 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)
 (e) Means of injury _____
 23. Signature **E.P. Hagan** (M. D. or other) **MD**
 Address **Cooper's** Date signed **2/14/48**

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

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

Morris B. Jones

Licensed Embalmer No.

4322

P. O. Address

Buffalo 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.