

FILED NOV 28 1949

STANDARD CERTIFICATE OF DEATH

36898

State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1014

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield /		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield,	
c. LENGTH OF STAY (In this place) 35 Yrs		d. STREET ADDRESS (If rural, give location) 832 West Olive	
d. FULL NAME OF HOSPITAL OR INSTITUTION 832 West Olive		e. STREET ADDRESS 832 West Olive	

3. NAME OF DECEASED (Type or Print) a. (First) **Leona** b. (Middle) **Bennett** c. (Last) **Haeflinger**

4. DATE OF DEATH (Month) (Day) (Year) **Nov. 19 1949**

5. SEX F M /	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 4, 1886	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months 3 Days 15	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY Housekeeper		11. BIRTHPLACE (State or foreign country) Nixa, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME **Frank Bennett** 13b. MOTHER'S MAIDEN NAME **Amanda Alice Duncab** 14. NAME OF HUSBAND OR WIFE. **Deceased**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No**

16. SOCIAL SECURITY NO. **494-18-5542**

17. INFORMANT'S SIGNATURE OR NAME ADDRESS **George A. Anderson- 832 W. Olive**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Hypertensive, Cardio - Vascular Disease**

ANTECEDENT CAUSES (b) **Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.**

(c)

II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) **442 V**

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 9/24, 1949, to 11/19, 1949, that I last saw the deceased alive on 11/19, 1949, and that death occurred at 9:45 A.M. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Edward Marcus M.D.** 23b. ADDRESS **623 Woodrup Bldg** 23c. DATE SIGNED **11/21/49**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **11-22-1949** 24c. NAME OF CEMETERY OR CREMATORY **Payne** 24d. LOCATION (City, town, or county) (State) **near Nixa, Missouri**

DATE REC'D BY LOCAL REG. **11-21-49** REGISTRAR'S SIGNATURE **W.S. Handley** 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Springfield, Missouri**

(Licensed Embalmer's Statement on Reverse Side)

Dr. Marcus WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed H. L. McCain

Licensed Embalmer No. 2727

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.