

24980  
FILED SEP 27 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 30297

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>873</u>	
1. PLACE OF DEATH a. COUNTY <b>GREENE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>SPRINGFIELD</b>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>SPRINGFIELD</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>615 N. ROGERS</b>				f. STREET ADDRESS (If rural, give location) <b>615 N. ROGERS</b>			
3. NAME OF DECEASED a. (First) <b>ANNIE</b>			b. (Middle)			c. (Last) <b>HEMENWAY</b>	
4. DATE OF DEATH <b>SEPT. 17, 1954</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	
8. DATE OF BIRTH <b>13 APRIL 1860</b>		9. AGE (In years last birthday) <b>94</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>IN HOME</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>CANADA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>WILLIAM MURCHESON</b>		13b. MOTHER'S MAIDEN NAME <b>JEANETTE URQUHEART</b>		14. NAME OF HUSBAND OR WIFE <b>DECEASED</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>ELSTON HEMENWAY (SON) SPRINGFIELD, MO.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hemorrhage, Cerebral</b>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		21f. HOW DID INJURY OCCUR?	
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 <u>9, 15,</u> 19 <u>54,</u> to <u>9, 17,</u> 19 <u>54</u> that I last saw the deceased alive on <u>9, 17, 54,</u> 19 <u>    </u> , and that death occurred at <u>1:30P</u> m., from the causes and on the date stated above.						23. DATE SIGNED <b>9, 20, 54</b>	
23a. SIGNATURE <i>[Signature]</i>		23b. ADDRESS <b>505 Medical Arts Bldg Springfield, Missouri</b>		23c. DATE SIGNED <b>9, 20, 54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>9-18-54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>MAPLE PARK CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MISSOURI</b>	
DATE REC'D BY LOCAL REG. <b>9-21-54</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. W. Klingner &amp; Co. Springfield, Mo.</b>			

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.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.**

**If this body is not embalmed, fact should be so stated above.**