

13-40  
17-39  
X25159

**MAY 13 1941**  
318

Registration District No. \_\_\_\_\_ Primary Registration District No. 2001

9  
2  
6  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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:  
316 W. Atlantic  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 20 Years / \_\_\_\_\_ (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield, Mo.  
(If outside city or town limits, write "RURAL") 21

(d) Street No. 316 W. Atlantic,  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Ida Frances White

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased November 26 1866  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20  
year 1941 hour 12 minute 30A M.

21. I hereby certify that I attended the deceased from 4/15/41  
\_\_\_\_\_ 19\_\_\_\_ to 4/20 \_\_\_\_\_ 1941  
that I last saw her alive on 4/19 \_\_\_\_\_ 1941  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

<u>74</u>	<u>4</u>	<u>24</u>	_____ hr. _____ min.
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Immediate cause of death Chronic nephritis 12/18 3 Duration

Due to \_\_\_\_\_

Due to Heart affected Chronic Hypertension  
secondary to

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace Unknown / Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Henry Fralick

13. Birthplace Unknown / Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name Angeline Cooper

15. Birthplace Unknown / Kentucky  
(City, town, or county) (State or foreign country)

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?  
At home

(Specify type of place) \_\_\_\_\_  
While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

Signature W. E. Handley (M. D. or other) \_\_\_\_\_  
Address Springfield Date signed 4/21/41

16. (a) Informant Mrs. Bertha Davis

(b) Address 316 W. Atlantic Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/41  
(Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn (Cem)

18. (a) Signature of funeral director Dunn Funeral Home

(b) Address Springfield, Mo.

19. (a) 4-22-41 (Date received local registrar)

(b) W. E. Handley (Registrar's signature)

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**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

*Raymond W. Fox*

Licensed Embalmer No. *2910*

P. O. Address

*629 W Walnut*

**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.**

X