

No. 2
5-42
17-39
X32873

FILED AUG 9 1943

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4 1/2 Mi. N. of Granby, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 2 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 4 1/2 Mi. N. of Granby, Mo.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Ellen S. Renfro

3. (b) If veteran, name war _____ No. _____

(c) Social Security _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 year 1943 hour 9:00 minute P. M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Freeman S. Renfro 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased: August 27, 1906
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 21, 1943 to July 21, 1943 that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

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

36 9 24 hr. min.

Immediate cause of death: Cerebral hemorrhage

Due to: High blood pressure

Due to _____

9. Birthplace: Newton Co., Mo.
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death)

10. Usual occupation: Housewife

PHYSICIAN

Major findings: 8301

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name John D. Jones

13. Birthplace Little Rock, Arkansas
(City, town, or county) (State or foreign country)

14. Maiden name Martha Larymore

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

22. If death was due to external causes, fill in the following:

16. (a) Informant Freeman S. Renfro

(b) Address Granby, Mo. Rt. #1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-1943
(Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director W. D. Hoon

(b) Address Cassville

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

(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? _____

While at work? _____ (Specify type of place)

(e) Means of injury 0

23. Signature J. C. Edwards (M. D. or other) _____

Address 12111a mo. Date signed 7/24/43

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

RECEIVED

District Health Officer No. *8-6-43*

District File Number *843-153*

Date Filed *8-2-43*

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

Wm. C. Koon

Registered Apprentice No.

338

working under my personal supervision.

Signed

W. C. Koon

Licensed Embalmer No.

2456

P. O. Address

Cassville 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.

Registration District No. 244

Primary Registration District No. (5834)

Registrar's No. 25-

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Rural (Marion)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
7 1/2 mi. n. of Starby, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Newton

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ellen S. Renfro

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife Irueman H. 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased aug 27 1882
(Month) (Day) (Year)

8. AGE: Years 36 Months 9 Days 14 (If less than one day, _____ min.)

9. Birthplace Newton, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name John J. Jones

13. Birthplace Stettin, Co. Ark.
(City, town, or county) (State or foreign country)

14. Maiden name Martha Farmore

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

16. (a) Informant Irueman H. Renfro

(b) Address Starby, Mo.

17. (a) Rural (b) Date thereof 7-24-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greendwood

18. (a) Signature of funeral director W. D. Koon

(b) Address Cassville

19. (a) 8-18-1943 (b) Mrs. U. S. Chapman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration _____

Due to High blood pressure

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

TEMPORARILY

PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. -----
District File Number 943-176-----

Date Filed 9-9-43-----

S-25624