

FILED MAY 16 1945
1945

Registration District No.

Primary Registration District No.

3038

451

1. PLACE OF DEATH

(a) County Linn
(b) City or town Brookfield
(c) Name of hospital or institution Brookfield Hospital
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn
(c) City or town Brookfield
(d) Street No. Route #3
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CONNIE SUE RENSHAW

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased Apr - 15 - 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. 40 min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Finnis Renshaw
13. Birthplace Kirkville Mo
14. Maiden name Gene S. Inefer
15. Birthplace Linn Mo

16. (a) Informant Finnis Renshaw

(b) Address Brookfield Mo

17. (a) Burial (b) Date thereof Apr - 15 - 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Michael Cem

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

(b) Address Brookfield Mo

19. (a) 4-15-1945 (b) H H Cannon
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 15
year 1945 hour 9 minute 40 A.M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw her alive on Apr 15 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Spontaneous myocardial infarction
Duration _____

Due to Spontaneous myocardial infarction

Due to Coronary atherosclerosis

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

Major findings: Of operations _____
Of autopsy 159

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? _____

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature W. J. Shannon (M. D. or other) DO
Address Brookfield, Mo. Date signed 4-16-45

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

RECEIVED

District Health Officer No. 11;

District File Number.....

Date Filed.....

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.....

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