

STANDARD CERTIFICATE OF DEATH

2665

State File No.

Registration District No. 3462126 Primary Registration District No. 1265462 Registrar's No. 12

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Fair Grove, Taney Co.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Rps 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution new days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Etting Mamie Anderson

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive - years

7. Birth date of deceased 12-17-1876  
(Month) (Day) (Year)

8. AGE: Years 69 Months 0 Days 0 If less than one day hr. min.

9. Birthplace St. Clair Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation house wife

11. Industry or business

12. Name Arthur B. Ferr

13. Birthplace Indiana  
(City, town, or county) (State or foreign country)

14. Maiden name Rebecca Summers

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

16. (a) Informant Mrs. Ernest Eli

(b) Address Fair Grove Mo.

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

(c) Place: burial or cremation Ash Grove

18. (a) Signature of funeral director Morris Leman

(b) Address Ash Grove Mo.

19. (a) Dec 17 1945 (b) Mrs Porter O'Neil  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Ash Grove  
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 17  
year 1945 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from Dec 10 1945 to Dec 17 1945  
that I last saw her alive on Dec 17 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis Duration 7 days

Due to

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?

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

23. Signature Shayne Gonnemann M.D. or other MD  
Address Fair Grove Date signed 12/17/45

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

County Health Office,  
County No. Number 46-2-15  
Date Filed 2-7-46

**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 L. B. Lerman  
Licensed Embalmer No. 3297  
P. O. Address Miller 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. 126

Primary Registration District No. 5462

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

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

In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Emma M. Anderson

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 wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 17  
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 13 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

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

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec (Day) \_\_\_\_\_ year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Chronic Nephritis

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

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

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

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

Of autopsy 131h

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 \_\_\_\_\_

23. Signature H. Goussman (M. D. or other) Do.  
Address Fair Grove, Mo. Date signed 2/13/46

**SUPPLEMENTARY**

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

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

100146 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

2605