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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED** MAR 11 1948

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5233

State File No. \_\_\_\_\_

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 126

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: 216 E. Division 1  
(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 Greene 39

(c) City or town Springfield 2  
(If outside city or town limits, write "RURAL") 6

(d) Street No. 216 E. Division St.  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Annie Fahrenhorst

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 4th  
year 1946 hour 9 minute 45 A.M.

21. I hereby certify that I attended the deceased from 12-6- 1945 to 2-4- 1946  
that I last saw ~~her~~ alive on 2-4- 1946  
and that death occurred on the date and hour stated above.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife William C. Fahrenhorst

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased October 9, 1872  
(Month) (Day) (Year)

Immediate cause of death Carcinoma of breast Duration 1 yr

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>73</u>	<u>3</u>	<u>25</u>	hr. _____ min.

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

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

9. Birthplace Detroit Mich. 1  
(City, town, or county) (State or foreign country)

Other conditions 50  
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings: 50  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business At Home

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

12. Name Thomas Glynn

13. Birthplace Sandwich Ontario 2  
(City, town, or county) (State or foreign country)

14. Maiden name Nancy A. Maddock

15. Birthplace Camden Ohio 1  
(City, town, or county) (State or foreign country)

16. (a) Informant William C. Fahrenhorst

(b) Address 216 E. Division Springfield

17. (a) Burial (b) Date thereof 2-6-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director J. W. Kingner & Co.

(b) Address Springfield Mo.

19. (a) 2-5-46 (b) W. H. Handley  
(Date received local registrar) (Registrar's signature)

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 C. E. Feller (M. D. or other) \_\_\_\_\_

Address Springfield Mo. Date signed 2-4-46

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

MAY 5 1948

DEPT. OF HEALTH

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. 4071

P. O. Address Spring Hill

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.