

FILED APR 10 1946

Registration District No. **181**

Primary Registration District No. **5678**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Louisville**
 (b) City or town **Louisville**
(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 _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Lincoln**
 (c) City or town **Louisville**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **EFFA FLEENER**

3. (b) If veteran, name war **X**
 3. (c) Social Security No. **710**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **single**
 6. (b) Name of husband or wife **X** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Sept 26 1875**
(Month) (Day) (Year)

8. AGE: Years **70** Months **6** Days **2** If less than one day _____ hr. _____ min.

9. Birthplace **Louisville MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business _____

MOTHER { 12. Name **John Fleener**
 13. Birthplace **Bloomington Indiana**
(City, town, or county) (State or foreign country)
 14. Maiden name **Drucilla Murphey**
 15. Birthplace **Old Dixton MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Nora Burbidge**
 (b) Address **High Hill MO**

17. (a) **Burial** (b) Date thereof **Mar 31 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Louisville MO**

18. (c) Signature of funeral director **Wace Bentler**
 (b) Address **Bayling Green MO**

19. (a) **4/2/46** (b) **Mrs. L. A. Dwyer**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **28**
 year **1946** hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from **1928**
 _____, 19____, to _____, 19____
 that I last saw him alive on **3/27**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Emphysema**
 Due to **Endocarditis**
ADDITIONAL SUPPLEMENTARY INFORMATION

Other conditions **Typhoid**
(Include pregnancy within 3 months of death)
 Major findings: **This was a Cardiac Vascular Renal complication**
 Of operations _____
 Of autopsy _____

PHYSICIAN
 Underline the cause to which death should be charged statistically.
3/11

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? _____ (c) Means of injury _____
 23. Signature **J. M. Shue** (M. D. or other) _____
 Address: **Township Green MO** Date signed **4/4/46**

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 *Grace M. Tompkins*

Licensed Embalmer No. *2204*

P. O. Address *Bowling Green*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. _____

Registration District No. 181

Primary Registration District No. 5678

1. PLACE OF DEATH:
(a) County Lincoln
(b) City or town Louisville
(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 Effa Fleener
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 S

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

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

8. AGE: Years 70 Months _____ Day _____ (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 _____

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

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

Immediate cause of death _____
Duration _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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

MOTHER FATHER

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