

No. 2
1-5-43
5-17-39
I X36671

30041

State File No. _____

FILED 0928 9 1946

Registration District No. _____ Primary Registration District No. 2000

Registrar's No. 765

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:
228 E. Thoman /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community _____ (Specify whether 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")

(d) Street No. 228 E. Thoman 6
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME Hattie E. Wells

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sep. day 21
year 1946 hour 6 minute 00 p. m.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

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

7. Birth date of deceased Nov. 7, 1880
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 9-21-1946 to 9-21-1946 1946
that I last saw him alive on 9-21-1946
and that death occurred on the date and hour stated above.

8. AGE: 65 Years 10 Months 14 Days
If less than one day _____ hr. _____ min.

Immediate cause of death Angina Pectoris

Due to _____

Due to _____

9. Birthplace Carroll Co. Ark.
(City, town, or county) (State or foreign country)

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

Major findings: 94B

Of operations _____

Of autopsy _____

10. Usual occupation House wife

11. Industry or business At Home

12. Name Robert Dickens

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Charles Sater

(b) Address Springfield Mo.

17. (a) Burial (b) Date thereof 9-24-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Robberson Prairie

18. (a) Signature of funeral director J. W. Ringner

(b) Address Springfield Mo.

19. (a) 9-24-46 (b) J. J. Howard
(Date received local registrar) (Registrar's signature)

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? _____

(Specify type of place)

While at work? _____ (e) Means of injury 0

23. Signature W. Kelly (M. D. or other) _____

Address Springfield Mo Date signed 9-24-46

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

MOTHER FATHER

20046

9
2
6

14

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 Roy A. Cairns
Licensed Embalmer No. 1763
P. O. Address Springfield

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.

XO