

No. 2
12-45
17-39
X47070

FILED FEB 28, 1947

Registration District No. **128**

Primary Registration District No. **2000**

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

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:
1241 N. Summit Ave., /
(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**
(If outside city or town limits, write "RURAL")
(d) Street No. **1241 N. Summit Ave.,** **97**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Ella Dymond Pain**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** / 5. Color or race **White** / 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **George H. Pain** 6. (c) Age of husband or wife if alive **80** years

7. Birth date of deceased **March 9 1875**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 11 10 2 28 hr. min.

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

10. Usual occupation **House Wife**

11. Industry or business **At Home**

12. Name **William Beeler** **Unknown** **9**

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

14. Maiden name **Caroline R. West.** **9**

15. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **George H. Pain**

(b) Address **Springfield Mo.**

17. (a) **Burial** (b) Date thereof **2/13/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood**
Springfield Mo.

18. (a) Signature of funeral director **J. W. Klingner & Co.**
(b) Address **Springfield Mo.**

19. (a) **2-12-47** (b) **W. Handy MD**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **11**
year **1947** hour **7** minute **50 A.** M.

21. I hereby certify that I attended the deceased from **Feb 8**, 19**47**, to **Feb 11**, 19**47**.
that I last saw h. **ER** alive on **Feb 8**, 19**47**;
and that death occurred on the date and hour stated above.

Immediate cause of death **chronic nephritis with uremia** Duration **1 year.**

Due to _____
Due to _____

Other conditions: **121 B**
(Include pregnancy within 3 months of death)

Major findings: **121 B**
Of operations _____
Of autopsy _____

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 _____

23. Signature **Gene Fathing** (M, D or other) **D**
Address **Hoeland Bldg,** Date signed **Feb 12, 47**

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 *Max Rhodes*

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.