S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 5 1947

Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13179

Primary Registration District No. 2000

Registrar's No. 382

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: Burge Hosp. O (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 8 Days (Specify whether years, months or days)
In this community: Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene 39
(c) City or town: Springfield 2 (If outside city or town limits, write "RURAL")
(d) Street No.: 706 W. Walnut 6 (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Blanche Gertrude Shank
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Orin B. Shank
6. (c) Age of husband or wife if alive: 74 years
7. Birth date of deceased: Nov. (Month) 14 (Day) 1874 (Year)

8. AGE: Years	Months	Days	If less than one day
72	5	10	hr. min.

9. Birthplace: Darlington (City, town, or county) Wisconsin (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: John L. Agnew
FATHER 13. Birthplace: (City, town, or county) Wisconsin (State or foreign country)
MOTHER 14. Maiden name: Carolyn Chilton
MOTHER 15. Birthplace: (City, town, or county) Missouri O (State or foreign country)
16. (a) Informant: Orin B. Shank
(b) Address: Springfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/26/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Hazelwood
18. (a) Signature of funeral director: H. H. Lohmeyer
(b) Address: Springfield, Mo.
19. (a) 4-25-47 (Date received local registrar) (b) W. C. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24 year 1947 hour 1 minute 25 a.m.
21. I hereby certify that I attended the deceased from May 28, 1946 to April 24, 1947 that I last saw her alive on April 23, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of the right rami of the inferior maxillary bone	
Due to:	March 28, 1946
Due to:	
Other conditions (Include pregnancy within 3 months of death): Metastasis of the lower cervical spine	

Major findings:
Of operations: 0
Of autopsy: None

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: Leslie R. Webb (M. D. or other)
Address: Springfield, Mo. Date signed: 4/24/47

(Licensed Embalmer's Statement on Reverse Side)

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 Walter E Hamilton

Licensed Embalmer No. 3808

P. O. Address Springfield 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.