

FILED JUL 26 1947

Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

Registrar's No. 630

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

29  
2  
6

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: 923 S. Nettleton  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community Three yrs  
years, months or days

3. (a) PRINT FULL NAME Ellie Probinette

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

4. Sex F  
 5. Color or race wh  
 6. (a) Single, widowed, married, divorced   
 6. (b) Name of husband or wife Ed Probinette  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased July 18, 1865  
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 20  
If less than one day  
 hr. \_\_\_\_\_ min.

9. Birthplace Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
 12. Name Edward Progers  
 13. Birthplace Indiana  
(City, town, or county) (State or foreign country)  
 14. Maiden name Jarah Sheets  
 15. Birthplace Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant Reneil Kracke  
 (b) Address Malena Mo

17. (a) Burial (b) Date thereof 7-15-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenham

18. (a) Signature of funeral director Everett Cheatham

(b) Address Malena Mo

19. (a) 7-14-47 (b) W E Handley MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
 (c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 923 S. Nettleton  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13  
 year 1947 hour 1:00 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 6, 16, 47, 19, to 7, 13, 47, 19;  
 that I last saw her alive on 7, 11, 47, 19,  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 27 days

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:

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 W J Smick (M. D. or other) \_\_\_\_\_

Address Springfield, Mo Date signed 7, 14, 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 Ernest J. Cheatham

Licensed Embalmer No. 3870

P. O. Address Galena 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.**