

FILED OCT 27 1947

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 911

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 Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 days
(Specify whether years, months or days)

In this community _____
years, months or days

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. 850 South Weaver Avenue
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME FLORENCE H. FOSTER

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 20, year 1947 hour 2: minute 30 P. M.

21. I hereby certify that I attended the deceased from Oct. 1, 1947 to Oct. 20, 1947 that I last saw her alive on Oct. 20, 1947 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased August 20, 1875
(Month) (Day) (Year)

Immediate cause of death Miocardial Insufficiency

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>2</u>	<u>0</u>	hr. _____ min.

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 _____

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

10. Usual occupation Housewife

11. Industry or business Home Makeing

MOTHER FATHER { 12. Name Wm. T. Hankins

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

14. Maiden name Mary Jane Comstock

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

23. Signature Leslie B. With (M. D. or other) _____
Date signed 10-22-47

Address Springfield, Mo.

16. (a) Informant Joe W. Foster (son)

(b) Address Columbia, Missouri

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 10/23/1947
(Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cem.

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 10-22-47 (Date received local registrar)

(b) W. J. Handley, M.D. (Registrar's signature)

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

9
2
6

Duration
9 mo.

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

MAY 19 1948

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.....

..... Lee Mason, Registered Apprentice No. 477,
working under my personal supervision.

Signed

Jewell E. Kunkle

Licensed Embalmer No. *2831*

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.