

FILED SEP 27 1948 8/21

Registration District No. \_\_\_\_\_ Primary Registration District No. 5464

Registrar's No. 28

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Rural Murray Twp.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R. F. D. # 2.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 39 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene

(c) City or town Willard  
(If outside city or town limits, write "RURAL")

(d) Street No. R. F. D. # 2  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ruth M. Atwood

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 Ray Atwood

6. (c) Age of husband or wife if alive June 8, 1909 years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

39 3 3 hr. min.

9. Birthplace Fair Grove Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business At Home

12. Name Dee H. Huff.

13. Birthplace Fair Grove Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Kaude Warren

15. Birthplace Greene County Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Ray Atwood

(b) Address Willard Mo. R # 2

17. (a) Burial (b) Date thereof Sep. 14\*48  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address Springfield Mo.

19. (a) 9/18/48 (b) Steve H. Wilson  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 11  
year 1948 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1943, to Sept 11, 1948.  
that I last saw her alive on Sept 11, 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic Heart Disease

Duration 5 yrs.

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 MO.

23. Signature May Hill (M. D. or other) MO.  
Address Springfield Mo. Date signed 9-14-48

RECEIVED

Greene County Health Office,

County File Number 48-9-71

Date Filed 9-25-48

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.....

John L. Mitchell, Registered Apprentice No. 85  
working under my personal supervision.

Signed J. B. Klingner  
Licensed Embalmer No. 3358  
P. O. Address.....

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.