

6-300
10-47
17-39
I 3906

FILED DEC 6 1948
Registration District No. _____

Primary Registration District No. **2000**

Registrar's No. **1042**

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 **2 months**
(Specify whether years, months or days)

3: (a) PRINT FULL NAME **Fannie C. Williams**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Female** race **WHITE**

5. Color or race **WHITE**

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **Aug 21 1858**
(Month) (Day) (Year)

8. AGE: Years **90** Months **3** Days **6** If less than one day _____ hr. _____ min.

9. Birthplace **unknown Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **J. Puler**

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

14. Maiden name **unknown Ballouff**

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

16. (a) Informant **Walter Ballouff**

(b) Address **1822 First National Bldg. Springfield Mo.**

17. (a) **Removal** (b) Date the coffin was buried, cremated, or removed **Sept 26 1948**
(Month) (Day) (Year)

(c) Place: burial or cremation **Crown Hill Cemetery Springfield Mo.**

18. (a) Signature of funeral director **Walter Ballouff**

(b) Address **1822 First National Bldg. Springfield Mo.**

19. (a) **Nov. 29, 1948** (b) **W. E. Handley, M.D.**
(Date obtained local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lawrence**

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

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** Day **27**
Year **1948** hour **8** minute **32** P. M.

21. I hereby certify that I attended the deceased from **Sept 27** 1948, to **Nov 27** 1948;
that I last saw her alive on **Nov 27** 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Failure** Duration **4 days**

Due to **arteriosclerosis** **years**

Due to **Nephritis - renal** **Month**

Other conditions **Fracture of hip** **2 months**
(include pregnancy within 3 months of death)

Major findings: **Senile psychosis** **PHYSICIAN**
Of operations _____
Of autopsy **10/16**
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 **accident** **55**

(b) Date of occurrence **Sept 26 1948**

(c) Where did injury occur? **Marionville Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home (Specify type of place)

While at work? _____ (e) Means of injury **Fall**

23. Signature **Daniel L. Jancy** M. D. or other _____
Address **Springfield Mo.** Date signed **Nov 27 48**

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

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 *Leonard B. Jones*

Licensed Embalmer No. *2508*

P. O. Address *Buffalo 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.