

REC'D FEB 15 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2293

Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 316
(b) Township _____ Primary Registration District No. 2001
(c) City SPRINGFIELD (d) Street No. Springfield Baptist Hospital Registered No. 28
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. Harrisonville Mo
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 14 - 1913

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
25 2 25

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. teacher
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Pleasant Gap Mo
(STATE OR COUNTRY) Bates Mo

FATHER 13. NAME H M Beare

14. BIRTHPLACE (CITY OR TOWN) Pleasant Gap Mo
(STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Lawana Cox

16. BIRTHPLACE (CITY OR TOWN) Attawa
(STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) H M Beare
Harrisonville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Harrisonville Mo DATE Jan 9 1939

19. FUNERAL DIRECTOR (NAME) R L Henschel
(ADDRESS) Licking Mo

20. FILED Jan 9 1939 Chas A George
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 9 193922. I HEREBY CERTIFY, That I attended deceased from Jan 6 1939 to Jan 9 1939

I last saw him alive on Jan 9 1939. Death is said to have occurred on the date stated above, at 9:45 a.m.

The principal cause of death and related causes of importance were as follows:

Cerebral Concussion
Automobile accident while driving automobile

Other contributory causes of importance:

Name of operation Reduction of T/F Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external cause (violence), fill in also the following:

Accident, suicide, or homicide? Accident Date of injury 1-6 1939Where did injury occur? on way to home Bates Mo

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury fall accidentNature of injury Cerebral Concussion

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) E L Gough M. D.(Address) Springfield Mo

7/10/20

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.....

Licensed Embalmer No.....

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

2293
Do not use this space.

1. PLACE OF DEATH
 (a) County Greene Registration District No. 318
 (b) Township Springfield Primary Registration District No. 2001 Registered No. 28
 (c) City Springfield (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Howard Cecil Bearce
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S
 (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>26</u>	<u>2</u>	<u>25</u>	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____
 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
 PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Mar 14 1939 Chas A George reg
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-9 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Cerebral concussion
auto accident while driving auto
non collision
 Date of case? _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) E. C. Roseberry, M. D.
 (Address) Springfield Mo

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

No fee shall be charged for the preparation of a certificate of death. Exact statement of OCCUPATION is very important.

S-2293