WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

50M-9-1938 I X16805

MAR 13 1939

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

10878
Do not use this space.

1. PLACE OF DEATH Greene 3
(a) County ..... Registration District No. 318
(b) Township N. Springfield Primary Registration District No. 5439 Registered No. 228
or
(c) City Springfield (d) Street No. Co. Transient Camp. 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 624 JEFFERSON ARGYLE
(a) Residence, No. R#11 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 Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Unknown
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown
7. AGE about YEARS 83 MONTHS DAYS If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Unknown
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) Unknown 9

FATHER
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 9

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

17. INFORMANT (ADDRESS) Floyd Dixon Supt Co. Farm R#11 Springfield. Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Hazelwood DATE March 16, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. Kingner & Co. Springfield. Mo.
20. FILED 3-16, 1939 Chas A George MD Local Registrar 29

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 15, 1939
22. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1939, to Mar. 15, 1939
I last saw him alive on Mar. 15, 1939 Death is said to have occurred on the date stated above, at 3 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis with Myocardial degeneration	1930
Other contributory causes of importance:	
Chronic Nephritis	1930

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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. Mullinks, M. D.
(Address) Greene Co Health Dept Springfield Mo

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was not embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Roy A. Lauer

Licensed Embalmer No. 1763

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, above space should be left blank.