

REC'D MAY 11 1939

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

14863
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. 295
(c) City SPRINGFIELD (d) Street No. 935 S Jefferson 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 935 S Jefferson 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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 1861

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
77 6

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as saw mill, bank, etc. James
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) Texas Co

FATHER
13. NAME Thomas Whillier

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tex

MOTHER
15. MAIDEN NAME Mrs. Telso

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Mrs. Edward Jones
Springfield, Mo

18. BURIAL, CREMATION, OR REMOVAL Bynesville, Mo DATE 4/8 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. H. Tompkins
Springfield, Mo

20. FILED Apr 7 1939 Chas. D. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/6 1939

22. I HEREBY CERTIFY, That I attended deceased from April 5, 1939, to April 5, 1939.
I last saw him alive on April 5, 1939. Death is said to have occurred on the date stated above, at 4 p.m.
The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage Date of onset 4/5/39

Other contributory causes of importance: g. h. i.

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) Ray D. Callaway, M. D.

(Address) Springfield, Mo

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 *Walter E. Hammler*

Licensed Embalmer No. *3808*

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.

X