

REC'D JUN 8 1939

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

18688
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 318
(b) Township Campbell Primary Registration District No. 540 Registered No. 392
(c) City SPRINGFIELD (d) Street No. MEDICAL CENTER FOR FEDERAL PRISONERS 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 0 yrs. 2 mos. 14 da. (f) How long in U. S., if of foreign birth? 51 yrs. mos. da.

2. PRINT FULL NAME CUTTLE, George

(a) Residence, No. _____ St. Mendota, Illinois
(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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr. 9, 1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
56 1 0

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Barber
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) Unknown
11. Total time (years) spent in this occupation Unknown

12. BIRTHPLACE (CITY OR TOWN) Brookfield, Nova Scotia
(STATE OR COUNTRY) Canada

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) Nova Scotia
(STATE OR COUNTRY) Canada

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) Nova Scotia
(STATE OR COUNTRY) Canada

17. INFORMANT Deceased
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE Springfield, Mo. DATE 5-11-39 19

19. FUNERAL DIRECTOR (NAME) A. Lohmeyer Funeral Home,
(ADDRESS) Springfield, Mo.

20. FILED 5-11-39 19 Chas A. George, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 9, 1939 19

22. I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1939, 19, to May 9, 1939, 19

I last saw him alive on May 9, 1939, 19. Death is said to have occurred on the date stated above, at 6:20 p. m.
The principal cause of death and related causes of importance were as follows:

Date of onset
<u>Pyelitis, acute</u> Feb. '39
<u>Syphilis</u> Unknown
<u>Myelitis, transverse</u> Unknown
Other contributory causes of importance:
<u>Old fracture of vertebrae</u> Unknown
<u>Secondary anemia</u> Unknown

Name of operation None Date of _____

What test confirmed diagnosis? Clinical & Laboratory Was there an autopsy? No

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 of injury in any way related to occupation of deceased?
If so, specify _____
(Signed) L. Wilson, P. A. Surgeon, M. D.
(Address) Clinical Director, MCFP,
Springfield, Mo.

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.

1 X18603

- 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.

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