

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.

SEP 12 1939

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

29204
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE ³ Registration District No. 315
 (b) Township S. Campbell ² Primary Registration District No. 5440 Registered No. 643
 (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. 1 mos. 7 ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME BEARDEN, Walter

(a) Residence, No. _____ St. Foss, Okla.
 (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) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 18, 1905

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hr. ormin.
✓ 34 6 2

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

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

FATHER 13. NAME Jeff Bearden

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

MOTHER 15. MAIDEN NAME Mattie (?) Bearden

15. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY)

17. INFORMANT Deceased (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Elk City, OKLA. DATE 8-22-39 19.

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

20. FILED 8-21 1939 Chas. A. George MD Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 20, 1939 19

22. I HEREBY CERTIFY, That I attended deceased from July 13, 1939 19, to Aug. 20, 1939 19.

I last saw him alive on Aug. 20, 1939 19. Death is said to have occurred on the date stated above, at 10:15 p.m. M.
 The principal cause of death and related causes of importance were as follows:

Hodgkin's disease Mar. '39
726
 Other contributory causes of importance:

Name of operation Biopsy Date of Aug. 1939
 What test confirmed diagnosis? Clinical 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 or injury in any way related to occupation of deceased? No
 If so, specify _____

(Signed) E. W. Green, P. A. Surgeon, USPHS.
 (Address) Clinical Director, MCFP, 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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

X