

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

36090

Registrar's No.

780

Registration District No. 318

Primary Registration District No. 2001

1. PLACE OF DEATH:

- (a) County Greene **MISSOURI**
 (b) City or town Springfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

3. (a) PRINT NAME FULL NAME JENE MOAD

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife If

7. Birth date of deceased August 15 1939
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
 0 2 9 hr. min.

9. Birthplace Springfield Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Robert Moad13. Birthplace Dallas County Missouri
(City, town, or county) (State or foreign country)14. Maiden name Madys Banks15. Birthplace Miller County Missouri
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Robert J. Moad(b) Address 1120 E. Pine Sp. Me.17. (a) East Lawn (b) Date thereof Oct 25, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director F. C. Thivene(b) Address Springfield Mo.19. (a) Oct 24, 1939 (b) Chas. A. George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Greene
 (c) City or town Springfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1120 E. Pine
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 24th
 year 1939 hour 2 minute AM

21. I hereby certify that I attended the deceased from Oct 22
 1939, to Oct 23 1939
 that I last saw him alive on Oct 23 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Saut Kerau
Heart dissection, Saturday
Melastolic Bacteri

Due to Sch. Choked due to
renal sciss.

Due to Fracture of

Other conditions (Include pregnancy within 3 months of death)

Major findings: 12 C

Of operations XOf autopsy X

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature J. A. Robertson (M. D. or other) _____Address Springfield Mo Date signed 10/24/39

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.....

Self....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Ralph A. Diem

Licensed Embalmer No.....

3681

P. O. Address.....

Sp. 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.

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