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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39596

Registration District No. 318 DEC 15 1939

Primary Registration District No. 2001

Registrar's No. 815

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield 2
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2033 N Summitt
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County GREENE

(c) City or town Springfield, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 2033 N Summit
(If rural, give location)

(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME DAVID CECIL GOTT

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ✓

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased June (Month) 12 (Day) 1938 (Year)

8. AGE: Years ✓ 1 Months 4 Days 26 If less than one day hr. — min.

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

10. Usual occupation Infant

11. Industry or business at home

FATHER
12. Name Lon Gott
13. Birthplace Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Verla L. Rose
15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Verla L. Rose
(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9, 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Yeakley Chapel Co

18. (a) Signature of funeral director L. G. Wingfield Co
(b) Address Springfield, Mo.

19. (a) Nov 9 1939 (Date received local registrar) (b) Chas A George MD (Registrar's signature) ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov, day 8
year 1939 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from 11,7,39, 19__, to 11,8,39, 19__;
that I last saw him alive on 11,7,39, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, lobar-don't know duration, had been sick several wks. when brought to me-I saw it once-
Due to brought to my office 11,7,39

Due to

Other conditions (Include pregnancy within 3 months of death) 108

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury

29. Signature D Murrick (M. D. or other) 1
Address Springfield, Mo. Date signed 11,8,1939

(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 embalmed by me, or by.....

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

working under my personal supervision.

Signed William Max Rhode

Licensed Embalmer No. 4071

P. O. Address Spring Field

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

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