

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.

Registration District No. **378**

Primary Registration District No. **2001**

1. PLACE OF DEATH:

(a) County Greene **3**  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Pythian Home of Missouri  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 12 years 9 mos. 26 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Herculaneum  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years

3. (a) PRINT FULL NAME EDWARD ENGLSKIRCHER

8. (b) If veteran, name war No. 8. (c) Social Security No. 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 July 12 1861  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day hr. min.
	<u>78</u>	<u>4</u>	<u>10</u>	

9. Birthplace Memphis Tenn.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Laborer

11. Industry or business Lead Mines

MOTHER FATHER { 12. Name No Record  
18. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name No Record  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edl Gray

(b) Address Pythian Home

17. (a) Burial (b) Date thereof Nov. 24 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazleton

18. (a) Signature of funeral director M. C. Thomas

(b) Address Springfield Mo. 2

19. (a) 11-24-39 (b) Chas A George MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22<sup>nd</sup>  
year 1939 hour 4 minute 0 P. M.

21. I hereby certify that I attended the deceased from Nov 1  
\_\_\_\_\_, 19\_\_\_\_, to Nov. 22 3:30  
that I last saw him alive on Nov. 21 3:30  
and that death occurred on the date and hour stated above.

Immediate cause of death Ulcer of Stomach Duration 2 yrs

Due to Senility  
Due to 117 W

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations No Op.

Of autopsy None

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?

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

23. Signature W. R. Beatie (M. D. or other) \_\_\_\_\_  
Address 530 Med care bldg Date signed 11/24/39

Shuffled red

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**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

*Ralph Thorne*

Licensed Embalmer No. *3681*

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.**