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MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

14875

State File No. _____

MAY 1 1940 318
 Registration District No. _____

Primary Registration District No. 2001

Registrar's No. 331

1. PLACE OF DEATH:
 (a) County GREENE
 (b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Burge Hospital
(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

8. (a) PRINT FULL NAME Infant of Clifford & Helen Wilkerson
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex M 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 April 3, 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 3 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Clifford Wilkerson

13. Birthplace Rogersville, Mo
(City, town, or county) (State or foreign country)

14. Maiden name Helen Fippin

15. Birthplace Keetsville, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Clifford Wilkerson

(b) Address 727 New St.

17. (a) Burial (b) Date thereof 4/6, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood

18. (a) Signature of funeral director Dunn Funeral Home

(b) Address 629 W. Walnut, Springfield, Mo

19. (a) 4-6-40 (b) Chas. A. George M.D.
(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. 727 New St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3
 year 1940 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from apr 3
 19 40 to apr 3 40
 that I last saw him alive on apr 3 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Prematurity

Due to _____
 Due to _____

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

Major findings:
 Of operations _____
 Of autopsy _____

Duration

3 hrs

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?
290

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

23. Signature Fred R. Justhin M.D.

Address med art Bldg Date signed 3/5/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.