

MAY 13 1940

Registration District No. 378

Primary Registration District No. 2001

State File No.

Registrar's No.

350

1. PLACE OF DEATH:

(a) County GREENE
 (b) City or town Springfield
 (c) Name of hospital or institution: 615 S. DOUGLAS
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7
 (Specify whether years, months or days) 7.0

3. (a) PRINT FULL NAME WM HENRY WHITE3. (b) If veteran, name war 3. (c) Social Security No. 4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife Lona White 6. (c) Age of husband or wife if alive, years 7 18547. Birth date of deceased (Month) Sep (Day) 7 (Year) 18548. AGE: Years 85 Months 7 Days 2 If less than one day hr. min.9. Birthplace Indiana (City, town, or county) (State or foreign country)10. Usual occupation Farming11. Industry or business Farming12. Name James R. White13. Birthplace Ky. (City, town, or county) (State or foreign country)14. Maiden name Nancy Pa. Rose15. Birthplace Pa. (City, town, or county) (State or foreign country)16. (a) Informant's own signature Lona White(b) Address Springfield, Mo.17. (a) (Burial, cremation, or removal) Int. Grave, Mo. (b) Date thereof April 11-1940 (Month) (Day) (Year)(c) Place: burial or cremation Springfield, Mo.18. (a) Signature of funeral director W. H. Hargrett & Co.(b) Address Springfield, Mo.19. (a) 4-11-40 (Date received local registrar) (b) Chas. D. George (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
 (c) City or town Springfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 615 S. Douglas
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9th year 1940 hour 7 minute 00 P. M.21. I hereby certify that I attended the deceased from April 6 to April 9, 1940 that I last saw him alive on April 9, 1940 and that death occurred on the date and hour stated above.Immediate cause of death Chronic Tubercular Neck Lesions Duration 49

Due to _____

Due to _____

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

Major findings: Of operations _____

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) No

(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? NoWhile at work? No (Specify type of place) (e) Means of injury _____23. Signature Charles Williams (M. D. or other)Address Springfield, Mo. Date signed 4/10/40

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 ^{NOT}.....
No Embalming....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

J. B. Kluniger

Licensed Embalmer No. *3358*

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.

X