

FILED JUN 10 1942

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 350

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:
1229 West Avenue /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None
(Specify whether)
 In this community 50 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39
 (c) City or town Springfield, 6
(If outside city or town limits, write "RURAL")
 (d) Street No. 1229 West Avenue
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME John F. Sawyer

3. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Celeste Sawyer 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased. January 12, 1889
(Month) (Day) (Year)

8. AGE: Years 1 53 Months 3 Days 20 If less than one day
 hr. _____ min. _____

9. Birthplace Ash Grove, 0 Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Stationary Engineer

11. Industry or business Packing Company

MOTHER FATHER { 12. Name John F. Sawyer

13. Birthplace Unknown Indiana /
(City, town, or county) (State or foreign country)

14. Maiden name Mary M. Chilquitt

15. Birthplace Unknown Tenn. /
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Celeste Sawyer

(b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof 5 / 4 / 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clear Creek Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home While at work? _____ (Specify type of place) (e) Means of injury _____

(b) Address Springfield, Missouri

19. (a) 5-4-42 (b) E. W. Standley
(Date after local registrar) (Registrar's signature)
 Address Springfield, Mo Date signed 5-4-42

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2
 year 1942 hour 10 minute 10 P.M.

21. I hereby certify that I attended the deceased from 7-31-41 19, to 5-2-42 19, that I last saw him alive on 5-2-42 19, and that death occurred on the date and hour stated above.

Immediate cause of death malignant Tumor of Brain (cerebrum) Duration 9 mo

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

Major findings: Of operations Tumor of Brain

Of autopsy _____
 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? _____

23. Signature E. W. Standley (M. D. or other) _____
 Address Springfield, Mo Date signed 5-4-42

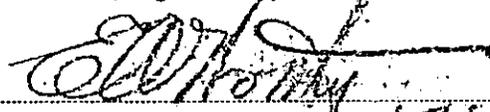
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

39
2
6

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.

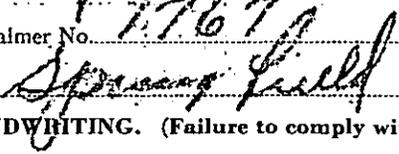
Signed.....



Licensed Embalmer No.....

1767

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, fact should be so stated above.

X