No. 2
4-13-40
5-17-39

14303

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 28 1943

Registration District No. ~~318~~ 128

Primary Registration District No. 2000

Registrar's No. 299

39 2 6

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

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: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 hours (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED: WRIGHT 114
(a) State Mo. (b) County
(c) City or town Mt Grove
(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.? No years.

3. (a) PRINT FULL NAME Francis Foley
3. (b) If veteran, name war NONE
3. (c) Social Security No. NONE
4. Sex M.
5. Color or race W.
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife Inf.
6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased 4 (Month) 13 (Day) 1943 (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 4 hr. 43 min.

9. Birthplace Springfield (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Infant
11. Industry or business at home
MOTHER FATHER
12. Name Jack Orr Foley
13. Birthplace Westplains (City, town, or county) Missouri (State or foreign country)
14. Maiden name Harriett Wakefield
15. Birthplace West Salem (City, town, or county) Wisconsin (State or foreign country)
16. (a) Informant Father
(b) Address Mountain Grove, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15 1943 (Month) (Day) (Year)
(c) Place: burial or cremation West Plains
18. (a) Signature of funeral director J W Klingner Co
(b) Address Springfield, Mo.
19. (a) 4-14-43 (Date received local registrar) (b) for M Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13th
year 1943 hour 9 minute 55 A.M.
21. I hereby certify that I attended the deceased from 5:12 A.M. - 4-13-1943 to 9:55 AM - 4-13-1943 that I last saw him alive on 4-13-43, 19..... and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Premature Birth (6 months gestation)
Due to Premature rupture of membranes
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 159
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Paul O. Graham, M.D. (M.D. or other)
Address Springfield, Mo. Date signed 4-13-43

(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 not embalmed by me, or by.....

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

working under my personal supervision.

Signed J. D. Klingner

Licensed Embalmer No. 3358

P. O. Address Springfield - Mo

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

If this body is not embalmed, fact should be so stated above.