

FILED JUL 2 1944  
Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield  
(c) Name of hospital or institution: St. John's Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 Minutes  
In this community 5 Minutes  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Boone  
(c) City or town Alpena Pass  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Whitaker - Infant

3. (b) If veteran, name war No 3. (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 None 6. (c) Age of husband or wife if alive KY years

7. Birth date of deceased June 19, 1944  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day hr. 5 min.

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

10. Usual occupation Child

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Frank Whitaker  
13. Birthplace Alpena Pass Arkansas  
(City, town, or county) (State or foreign country)  
14. Maiden name Vera Wasson  
15. Birthplace Summitt Arkansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frank Whitaker  
(b) Address Alpena Pass, Ark.

17. (a) Burial (b) Date thereof June 20, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Eastlawn

18. (a) Signature of funeral director H.H. Lohmeyer  
(b) Address Springfield, Mo.

19. (a) 6-20-44 (b) Sr. W.S. Hurdley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19  
year 1944 hour 1:00 minute a. M.

21. I hereby certify that I attended the deceased from June 19, 1944 to June 19, 1944  
that I last saw him alive on June 19, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity  
Due to Premature Labor

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

Major findings: 159  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence 7/2  
(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? \_\_\_\_\_ Means of injury \_\_\_\_\_  
23. Signature J. L. Johnston (M.D. or other) no  
Address Springfield, Mo. Date signed \_\_\_\_\_

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

29  
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.....

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.**

**This body not embalmed**