

Registration District No. 354

Primary Registration District No. 6203

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County TEXAS
 (b) City or town RURAL - CURRENT
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
10 M. N. SUMMERSVILLE
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1
 (Specify whether _____)
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State TEXAS (b) County TEXAS
 (c) City or town RURAL
 (If outside city or town limits, write "RURAL")
 (d) Street No. 10 M. N. SUMMERSVILLE
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME NOT NAMED SPRINGER

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month JUNE day 30
 year 1944 hour 4 minute _____ M.

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced 0

21. I hereby certify that I attended the deceased from 3:30 AM
48 to 9 AM, 1944

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

that I last saw him alive on JUNE 30, 1944
 and that death occurred on the date and hour stated above.

7. Birth date of deceased JUNE 30 1944
 (Month) (Day) (Year)

Immediate cause of death Premature Birth

8. AGE:	Years	Months	Days	If less than one day
				hr. <u>30</u> min.

Due to _____
 Due to _____

9. Birthplace TEXAS ADON
 (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) 159

11. Industry or business _____
 12. Name William J. Springer
 13. Birthplace Texas MO. U.
 (City, town, or county) (State or foreign country)
 14. Maiden name Edna
 15. Birthplace Texas MO. U.
 (City, town, or county) (State or foreign country)

PHYSICIAN _____
 Major findings: _____
 Of operations _____
 Of autopsy _____

16. (a) Informant Jeff Springer
 (b) Address 10 M. N. Summersville
 17. (a) Buried (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

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)

18. (a) Signature of funeral director None
 (b) Address _____
 19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____
 23. Signature Dr. Lavinia (M. D. or other) Do.
 Address Summersville Date signed June 30

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.

Not Embalmed
Signed.....

..... Licensed Embalmer No.

P. O. Address.....

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

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 255

Primary Registration District No. 6203

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Rural current sup
(c) Name of hospital or institution:

(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

3. (a) PRINT FULL NAME Joe Springer

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 30 1944
(Month) (Day) (Year)

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

9. Birthplace _____ (City, town, or county) (State or foreign country) mo.

10. Usual occupation _____

11. Industry or business _____

12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant J. W. Springer

(b) Address Harrison Mo

17. (a) Burial (b) Date thereof 6 30 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) July 1 44 (b) Mrs Paul Riley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Texas
(c) City or town Rural
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 30 Year 1944 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I have seen him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 159

Major findings: Of operations _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File No.

842448

Date Filed

9-1-44

06

[Faint handwritten signature]

25958