

FILED JAN 25 1945
128

Primary Registration District No. 2000

Registrar's No. 42

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: O'Reilly General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 192 days
(Specify whether years, months or days)
In this community 192 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Florida (b) County Manatee
(c) City or town Bradenton
(If outside city or town limits, write "RURAL")
(d) Street No. Box 426
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME RALPH P. WYMAN

3. (b) If veteran, name war WORLD WAR II 3. (c) Social Security No. UNK

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 XX years
7. Birth date of deceased May 9, 1921
(Month) (Day) (Year)

8. AGE: Years 23 Months 8 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Carpenter
11. Industry or business House construction

MOTHER FATHER { 12. Name William F. Wyman
13. Birthplace Archer Florida
(City, town, or county) (State or foreign country)
14. Maiden name Estelle (Unknown)
15. Birthplace Iowa City Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant WD, AGO Forms 20 and 24
(b) Address O'Reilly Gen. Hosp., Spfld, Mo
17. (a) Removal (b) Date thereof Jan. 15, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bradenton, Florida

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

19. (a) 1-15-45 (b) H. H. Lohmeyer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14
year 1945 hour 9 minute 20 A.M.

21. I hereby certify that I attended the deceased from 7 July 1944 to 14 January 1945;

that I last saw him alive on 14 January 1945;

and that death occurred on the date and hour stated above.
Immediate cause of death Hepatitis, infectious, severe, cause undetermined. Duration 10 days

Due to 32d

Due to _____

Other conditions Cataract, traumatic, sub-capsular; eye, right.
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____
— or autopsy Confirmation of above diagnoses. 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 Lee S. Lewis, M.D. (M.D. or other) _____
Address O'REILLY GEN. HOSP. Date signed _____

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

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Report submitted to the Bureau of the Census and to the health
authorities of Springfield, Missouri.

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 Walter E Hamilton
Licensed Embalmer No. 3808
P. O. Address Springfield Mo.

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.