

FILED MAR 12 1945
Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **140**

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:
1177 N. ROGERS AVE.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO.** (b) County **GREENE**
(c) City or town **SPRINGFIELD**
(If outside city or town limits, write "RURAL")
(d) Street No. **1177 N. ROGERS AVE**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **JAMES WADSWORTH BISHOP**
(b) If veteran, name war **NONE**
(c) Social Security No. **NONE**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **FEB.** day **19**
year **1945** hour **9** minute **45 P.M.**

4. Sex **MALE** 5. Color of race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
(b) Name of husband or wife **SARAH T. BISHOP**
(c) Age of husband or wife if alive **73** years
7. Birth date of deceased **NOV. 28-1864**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb. 14, 1945, 19 to Feb. 19, 1945, 19
that I last saw him alive on **Feb. 19, 1945, 19**
and that death occurred on the date and hour stated above.

8. AGE:
Years **80** Months **2** Days **21**
If less than one day
hr. min.

Immediate cause of death **Pulmonary edema**
Associated chronic nephritis
with uremia.
Due to Congestive heart disease.

9. Birthplace **UNK.** **UNK.**
(City, town, or county) (State or foreign country)
10. Usual occupation **RETIRED (15 YR) MACHINIST**

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

11. Industry or business
12. Name **JOHN BISHOP**
13. Birthplace **UNK.** **UNK.**
(City, town, or county) (State or foreign country)
14. Maiden name **JENNIE ROBERTS**
15. Birthplace **UNK.** **UNK.**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.
Major findings:
Of operations.....
Of autopsy.....

16. (a) Informant **Ruth Rader**
(b) Address **San Jose, Calif.**
17. (a) Burial (b) Date thereof **Feb 21-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Hazelwood Cem**
18. (a) Signature of funeral director **J.W. Klingner Co.**
(b) Address **Springfield, Mo.**
19. (a) 2-21-45 (b) **S. W. Havelly**
(Date received local registrar) (Registrar's signature)

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 **P. Andrew Murst** (M. D. or other) **AD**
Address **321 Woodruff Bldg** Date signed **2-20-45**

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 Roy A. Kaunt
Licensed Embalmer No. 1763
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.

X