

V. S. No. 2
 FORM-5-42
 Rev. 5-17-39
 I X32873

Dr. Horton
 State File No. 0158
 Registrar's No. 143

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED MAR 12 1945
 128
 STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. Primary Registration District No. 2000

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: Burge Hosp.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 Days
(Specify whether years, months or days)
 In this community 15 Years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Greene
 (c) City or town Springfield
(If outside city or town limits, write "RURAL")
 (d) Street No. 580 E. Elm
(If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Walter A. Pease

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 Married
 6. (b) Name of husband or wife Florence O. Pease 6. (c) Age of husband or wife if alive UNK years
 7. Birth date of deceased August 11, 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>6</u>	<u>9</u>	hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Mill Operator

12. Name Myron M. Pease

13. Birthplace UNK. Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Winnie Johnson

15. Birthplace UNK. Pennsylvania
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Florence Pease

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 2/21/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director H. H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 2-21-45 (b) Dr. W. G. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 20
 year 1945 hour 11:00 minute a. M.

21. I hereby certify that I attended the deceased from Feb. 17
 1945 to Feb. 20 1945;
 that I last saw him alive on Feb. 20 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death Shock Duration

Due to Burn, 2nd degree, wide area over the back.

Due to fall down in scalding water in bath tub at home

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

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident 133

(b) Date of occurrence Feb. 17, 1945

(c) Where did injury occur? Springfield, Greene Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? no (Specify type of place) (a) Means of injury Scalding Water

23. Signature James D. Horton (M. D. or other) M.D.

Address Springfield, Mo. Date signed 2/20/45

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

MOTHER FATHER

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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(Licensed Embalmer's Statement on Reverse Side)

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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 *L. Ashw Gorman*

Licensed Embalmer No. *3477*

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