

FILED APR 5 1945

Registration District No. 128

Primary Registration District No. 5462

Registrar's No. _____

1. PLACE OF DEATH:

(a) County GREENE
 (b) City or town PLEASANT HOPE
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
R.F.D. # 1
 (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County GREENE
 (c) City or town PLEASANT HOPE
 (If outside city or town limits, write "RURAL")
 (d) Street No. R.F.D. # 1
 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME CHANNING S. WADSWORTH

3. (b) If veteran, name war NONE
 3. (c) Social Security No. NONE

4. Sex MALE
 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced SINGLE
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: MAY 30 1857
 (Month) (Day) (Year)

8. AGE: Years 87 Months 9 Days 2
 If less than one day _____ hr. _____ min.

9. Birthplace La Grange Co. Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business Farming

12. Name Wm. Wadsworth

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

14. Maiden name Justah Hassinger

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

16. (a) Informant J. P. Wadsworth
(b) Address R # 1 Pleasant Hope Mo.

17. (a) Burial (b) Date thereof Mar. 4-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Comfort Em.

18. (a) Signature of funeral director J. W. Illiguer & Co.

(b) Address Springfield Mo.

19. (a) Mar. 4, 1945 (b) Mrs. Peter O'Neil
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 2
year 1945 hour 12 minute 00: NOON

21. I hereby certify that I attended the deceased from 2/28, 1945 to 3-2, 1945
that I last saw him alive on 2/28, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Protein Malnutrition
Duration 1 yr.

Due to _____

Due to _____

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

Major findings: Of operations gib

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 J. E. Feller (M. D. or other) _____

Address Springfield Mo. Date signed 3/4/45

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

MOTHER FATHER

RECEIVED

Greene County Health Office

County File Number 45-4-29

Date Filed 4-4-45

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 J. B. Klingner
Licensed Embalmer No. 3358
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.