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M-8-13
5-17-39
X37823

FILED AUG 13 1945
Registration District No. **128**

Primary Registration District No. **3000**

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: St John's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mon.
(Specify whether)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Texas 1A7

(c) City or town Cabool
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME CAPT. WALTER W. DURNELL

3. (b) If veteran, Spanish American and World War I name war _____

3. (c) Social Security No. unk.

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Charlotte Durnell

6. (c) Age of husband or wife if alive unk. years

7. Birth date of deceased Jan. 7, 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days 26 If less than one day _____ hr. _____ min.

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

10. Usual occupation REAL ESTATE DEALER

11. Industry or business _____

MOTHER FATHER { 12. Name CHARLES DURNELL

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

14. Maiden name MARtha STORRA

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

16. (a) Informant Mrs. W.W. Durnell

(b) Address Cabool Mo.

17. (a) Removal (b) Date thereof July 3, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cabool Mo.

18. (a) Signature of funeral director Robert Elliott

(b) Address Cabool Mo.

19. (a) 7-30-45 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3 year 1945 hour 3 minute 15A M.

21. I hereby certify that I attended the deceased from June 3, 1945 to July 3, 1945
July 2, 1945

that I last saw h. IM alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma prostate

Due to _____

Due to _____

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

Major findings: Cancer prostate

Of autopsy _____

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) _____

(e) Means of injury _____

23. Signature Robert W. J. [unclear] (M. D.) _____

Address Springfield MO Date signed 7-29-45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

E-1668

AUG 30 1945

SEP 1 1945

SEP 9 1945

AUG 20 1945

APR 25 1945

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. A. Roof*

Licensed Embalmer No. *3044*

P. O. Address *Springhill, Ala.*

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.

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