

No. 2
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2781
Registrar's No. 12

FILED FEB 2 1946
Registration District No. 5462

Primary Registration District No. -1-2-65462

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

1. PLACE OF DEATH:

(a) County Green
(b) City or town Fairgrove, Mo. Incl. in
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 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 Missouri (b) County Green
(c) City or town Fair Grove
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME John Willis Wammack
3. (b) If veteran, name war.....
3. (c) Social Security No.....

4. Sex Male 5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife.....
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased MAY 4 1970
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 7 14 hr. 0 min.

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

10. Usual occupation FARMER

11. Industry or business.....

MOTHER FATHER { 12. Name Daniel Wilson Wammack
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Susana Smith
15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address Hester Wammack
Fairgrove Mo.

17. (a) (b) Date there.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cendan Bluff

18. (a) Signature of funeral director W. J. ...
(b) Address Buffalo Mo.

19. (a) Dec. 19, 1945 (b) Mrs. Porter O'Neil
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 18
year 1945 hour 3 minute 30 A.M.
21. I hereby certify that I attended the deceased from Dec 13, 1945, to Dec 17, 1945
that I last saw him alive on Dec 17, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis ✓
Duration 1 wk.

Due to.....
Due to.....

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations.....
Of autopsy.....
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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) Means of injury.....

23. Signature W. J. ... or other Do
Address Fair Grove, Mo. Date signed 12/20/45

RECEIVED

Greene County Health Office

County File Number 46-9-14

Date Filed 2-7-46

FEB 18 1946

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 Louis B. Jones

Licensed Embalmer No. 4322

P. O. Address Buffalo, 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.

Registration District No. 126 Primary Registration District No. 5462

1. PLACE OF DEATH
(a) County Green
(b) City or town Saugone Franklin Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

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

3. (a) PRINT FULL NAME John W. Wammach
(b) If veteran, name wa _____
(c) Social Security No. _____

4. Sex m 5. Color or race white
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased may (Month) 4 (Day) 1945 (Year)
8. AGE: Years 75 Months 7 Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb Day 13 Year 1945 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Chronic nephritis
Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy 1311

Duration _____
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 Hayne Gammann (M. D. or other) 190
Address Fair Grove mo. Date signed Feb 13, 1945

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

SUPPLEMENTARY

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