

No. 2
-5-43
5-17-39
I X36671

FILED JUN 9 1947

Registration District No. **122**

Primary Registration District No. **2000**

Registrar's No. **427**

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:
O'Reilly V.A. Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 months 10 days
(Specify whether years, months or days)

In this community Time of hospitalization
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain

(c) City or town Farber, Missouri
(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 Charley Andrews

3. (b) If veteran, name war WW I

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Minnie Andrews

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased May 28, 1891
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>55</u>	<u>11</u>	<u>25</u>	hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business Agriculture

12. Name Robert Andrews

13. Birthplace No. Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Mary Frances Hunley

15. Birthplace No. Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant Clinical Records

(b) Address O'Reilly V. A. Hospital

17. (a) Removal (b) Date thereof MAY 23 - 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CANDALIA, MISSOURI

18. (a) Signature of funeral director Alvin Schaefer, Funeral Home

(b) Address 534 St. Louis St. Springfield, Mo.

19. (a) 5-22-47 (b) N.S. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22
year 1947 hour 6 minute 10 A M.

21. I hereby certify that I attended the deceased from February 11, 1947 to May 22, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, Pulmonary, far advanced, chronic, active, with possible tuberculosis enteritis.

Due to _____

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

Major findings: 13 B

Of operations _____

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?

While at _____ (Specify type of place)
(e) Means of injury _____

23. Signature Paul L. Eisele (M. D. or other) MD
Address O'Reilly VA Hosp. Date signed _____
Clinical Director.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

Lee Mason

Registered Apprentice No. *477*

working under my personal supervision.

Signed

Jewell E. Kiddle

Licensed Embalmer No. *2831*

P. O. Address

Springer, 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.