

S. No. 2
M-543
7. 5-17-39
I X38671

Ferguson

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27443
Registrar's No. 739

FILED SEP 15 1947
128

Registration District No. _____ Primary Registration District No. 2000

1. PLACE OF DEATH: **GREENE**

(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 Hosp. **O**

(If not in hospital or institution, write street number or location)

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

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene **39**

(c) City or town Springfield **2**
(If outside city or town limits, write "RURAL")

(d) Street No. 226 E. Division **6**
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No) **0**
If yes, name country.....

3. (a) PRINT FULL NAME James Lee Wood

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male **O**

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 Aug. 20 1947
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 22
year 1947 hour 12 minute 05a. M.

21. I hereby certify that I attended the deceased from Aug 20
6:35 P.M., 1947, to Aug. 22, 1947.

that I last saw h. / m. alive on Aug. 22, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital atelectasis
Duration 29 1/2 hrs.

8. AGE: Years Months Days If less than one day

- - 2 hr. min.

Due to Prematurity

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

Due to.....

10. Usual occupation Infant

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

11. Industry or business.....

Major findings:
Of operations.....

12. Name John H. Wood

Of autopsy.....

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

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

14. Maiden name Dolley Mae Spohn

15. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant John H. Wood

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 8/22/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GREENLAWN

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

(b) Address Springfield, Mo.

19. (a) 8-25-47 (b) M.E. Handley MD
(Date received local registrar) (Registrar's signature)

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..... **0**

23. Signature John P. Ferguson (M. D. or other) MD

Address Medical Arts Bldg Springfield, Mo Date signed Aug 23, 47

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

MOTHER FATHER

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.....

This body not embalmed.

Licensed Embalmer No.....

P. O. Address.....

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.