

FILED NOV 1 1948

State File No. 32643

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 978

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:
841 West Tampa 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community 17 years

3. (a) PRINT FULL NAME

John L. Wertin3. (b) If veteran,
name war no3. (c) Social Security
No. ?4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife Georgia Pearl Simpson Wertin 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased October 19 1878
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
70 0 4 hr. _____ min.9. Birthplace Wathena Kansas 1
(City, town, or county) (State or foreign country)10. Usual occupation retired11. Industry or business machinist12. Name Matthew Wertin13. Birthplace unknown Austria 4
(City, town, or county) (State or foreign country)14. Maiden name Mary Buthalz15. Birthplace Unknown Austria 4
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. John L. Wertin 1(b) Address Springfield, Missouri17. (a) Removal (b) Date thereof Oct. 25, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation St. Joseph Missouri18. (a) Signature of funeral director H. H. Lohmeyer(b) Address Springfield, Missouri19. (a) 10-25-48 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature) 111

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39
 (c) City or town Springfield 6
(If outside city or town limits, write "RURAL")
 (d) Street No. 841 West Tampa
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October Day 23
year 1948 hour 11 minute 30 a.m.21. I hereby certify that I attended the deceased from August 1947 to 10/23/48
that I last saw him alive on about 10-18-48 and that death occurred on the date and hour stated above.Immediate cause of death Lymphosarcoma with generalized metastases
Due to _____

Duration

since Aug 1947

Due to _____

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

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 (acc) (c) means of injury)23. Signature W. Roland Langston MD
Address Springfield Mo. Date signed 10/23/48

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.....

Walter E Hamiller

Licensed Embalmer No.....

3808

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.

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:
(a) County Shelby
(b) City or town Springfield
(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

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

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

7. Birth date of deceased Oct 19 1948
(Month) (Day) (Year)

8. AGE: Years 20 Months _____ 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 _____ (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)

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

When first seen had unilateral
Due to abscess + in situ nodes,
Bioxy from abscess + injured
Due to abscess showed lymphosarcoma.

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

Major findings: 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 work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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