

FILED JUN 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15516**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **471**

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give town) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Springfield	
c. LENGTH OF STAY (in this place) 12 hours		d. STREET ADDRESS (If rural, give location) 1621 South Delaware	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Johns Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) John	b. (Middle) M	c. (Last) Douglass	4. DATE OF DEATH (Month) (Day) (Year) May 27 1949
---	----------------------	---------------------------	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 5, 1908	9. AGE (In years last birthday) 40	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours Min.
--------------------	-------------------------------	---	--------------------------------------	---	------------------------	----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager (Dist)	10b. KIND OF BUSINESS OR INDUSTRY Kroger Grocery	11. BIRTHPLACE (State or foreign country) Memphis, Tennessee	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	--

13a. FATHER'S NAME John Douglass	13b. MOTHER'S MAIDEN NAME Maude L Fite	14. NAME OF HUSBAND OR WIFE Joyce Douglass
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Mrs Joyce Douglass	ADDRESS Springfield, Mo.
--	--	---	---------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		331X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **5/26**, 19**49** to **5/27**, 19**49** that I last saw the deceased alive on **5/27**, 19**49** and that death occurred at **12:30A** m., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title) M.D.	23b. ADDRESS 342 Med. Bldg. Springfield, Mo.	23c. DATE SIGNED 5/28
-----------------------------------	-------------------------------	---	------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE May 30, 1949	24c. NAME OF CEMETERY OR CREMATORY Memphis Cemetery	24d. LOCATION (City, town, or county) (State) Memphis Tennessee
--	-------------------------------	--	--

DATE REC'D BY LOCAL REG. 6/1/49	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS B.F.W. Springfield, Mo.
--	--	---	--

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

39
2
6

DEC 17 1949

DEC 5 1950

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Julian Goodwin

Signed _____
Student Embalmer

Licensed Embalmer No. 4562

P. O. Address Springfield

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.