DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 43360

Registration District No. 318 — Primary Registration District No. 2001 — Registrar's No. 3c-882

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield 2
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 783 E. Elm St.
(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 ____

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town 783 E Elm
(If outside city or town limits, write "RURAL")
(d) Street No. Springfield Missouri
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME WILLIAM N. FLY
3. (b) If veteran, name war —
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 Sarah L. Fly
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased March 20 1859 (Month) (Day) (Year)

8. AGE: Years 80 Months 8 Days 13 If less than one day ____ hr. ____ min.

9. Birthplace Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Retired Farmer
11. Industry or business On Farm
FATHER
12. Name D. C. Fly
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Margaret Woodward
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Ewly Blankenship
(b) Address Springfield. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Pleasant Cemetery
18. (a) Signature of funeral director L. W. Klingner & Co
(b) Address Springfield. Mo.
19. (a) 12-4-39 (Date received local registrar) Chas A. George M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3
year 1939 hour 7 minute 10 P. M.
21. I hereby certify that I attended the deceased from Dec 3, 1939 to Dec 3, 1939
that I last saw him alive on Dec 3, 1939
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	
Acute Dilatation of	
Due to Heart	
Due to	
Other conditions Senility 9 2/3 C	
(Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy No

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) No
(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 Walter A Lemell (M. D. or other) 1/14/40
Address Springfield Mo. Date signed 12-4-39

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No:.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.