

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

35731
Do not use this space.

REC. NOV 17 1938

1. PLACE OF DEATH

(a) County Greene Registration District No. 318
 (b) Township Springfield Primary Registration District No. 2001 Registered No. 801
 (c) City Springfield (d) Street No. St. Johns Hospital St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 263 Infant son of Mr. & Mrs. Theo. L. Achord St. _____
2018 N. Douglas (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct 28 - 1938</u>		
7. AGE YEARS <u>0</u>	MONTHS <u>0</u>	DAYS <u>0</u>
If LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Infant</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>at home</u>	
	10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Springfield, Mo.</u>		
FATHER	13. NAME <u>Theo. L. Achord</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>	
MOTHER	15. MAIDEN NAME <u>Mae Guthrie</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>	
17. INFORMANT (ADDRESS) <u>J. L. Achord, Springfield, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Green Lawn</u> DATE <u>Oct 28 1938</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>J. W. Klingner, Springfield, Mo.</u>		
20. FILED <u>Oct 28 1938</u> <u>Chas. A. George</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 Oct 28 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I have seen him/her alive on _____, 19____. Death is said to have occurred on the date stated above, at 9:50 P.M.
 The principal cause of death and related causes of importance were as follows:
Still born at 36th wk
macerated

Other contributory causes of importance: ?

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Joseph D. James, M. D.
 (Address) Springfield, Mo.

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.

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

J. B. Klingner

Licensed Embalmer No. *3358*

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, above space should be left blank.