

DEC 9 1938

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

29161

Do not use this space.

1. PLACE OF DEATH

- (a) County Greene Registration District No. 318
 (b) Township Scampbell Primary Registration District No. 2001 Registered No. 842
 (c) City Springfield (d) Street No. Springfield Baptist Hospital
 (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. 3 mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME DANIEL RAYMOND MENZIES

- (a) Residence, No. 1159 S. FERGUSON SE St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Baby</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 4 - 1938</u>		
7. AGE YEARS <u>0</u>	MONTHS <u>5</u>	DAYS <u>5</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		If LESS than 1 day, hrs. or min.
9. Industry or business in which work was done, as saw mill, bank, etc.		
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>Carl Raymond Menzies</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Springfield Mo</u>	
MOTHER	15. MAIDEN NAME <u>Lena Pearl Cochran</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Sedalia Mo.</u>	
17. INFORMANT (ADDRESS) <u>Carl Menzies 1159 S. Ferguson</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Green Lawn</u> DATE <u>11-10</u> 19 <u>38</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Denny Hall 629 Walnut St</u>		
20. FILED <u>11-10</u> 19 <u>38</u> <u>Chas. George</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov-9- 1938

22. I HEREBY CERTIFY, That I attended deceased from 11-8, 1938, to 11-9-38, 1938.
 I last saw him alive on 11-9-38, 1938. Death is said to have occurred on the date stated above, at 11-A.m.
 The principal cause of death and related causes of importance were as follows:
Broncho pneumonia
Toxic Encephalitis
 Date of onset 11-7-38
 Other contributory causes of importance: 11-8-38

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? no

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? no
 If so, specify (Signed) Wm. B. Buehler, M. D.
 (Address) Springfield, Mo

Licensed Embalmer's Statement on Reverse Side)

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.

1074

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 with the above constitutes grounds for revocation of license.)

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

39161
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 218
(b) Township Springfield Primary Registration District No. 3001 Registered No. 842
(c) City Springfield Street No. Spfld Hosp St. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(c) Length of residence in city or town where death occurred yrs. mos. ds. () How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Daniel Raymond Mengies #4 St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX W 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Mar 22 19 39 Chas. A. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 9 1938

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive on Nov 9, 1938. Death is said

to have occurred on the date stated above, at 10:10 m.

The principal cause of death and related causes of importance were as follows:

Broncho Pneumonia Date of onset

Other contributory causes of importance:

Toxic Encephalitis

No complications

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) _____, M. D.

(Address) _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AND PRESCRIBED BY LAW.

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.

