

REC'D JUL 11 1939

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

22119
Do not use this space.

1. PLACE OF DEATH
(a) County GREENE Registration District No. 316
(b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 474
(c) City SPRINGFIELD (d) Street No. Springfield Baptist 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 Chas B. Platt
(a) Residence, No. Green Forest, Ark 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) about April 1879
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 2 unknown
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. FARMER
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) Advance T.C.

FATHER 13. NAME Mitchell Platt 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Advance T.C.

MOTHER 15. MAIDEN NAME Alice B Williams 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Advance T.C.

17. INFORMANT (ADDRESS) Mrs Beulah Tate
Alpena ARKANSAS

18. BURIAL, CREMATION, OR REMOVAL PLACE Denver Ark DATE June 11th 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Nelson Funeral Home
Green Forest Ark 200

20. FILED 6-10 1939 Chas A. George MD Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9, 1939
22. I HEREBY CERTIFY, That I attended deceased from June 3, 1939 to June 9, 1939
I last saw him alive on June 9, 1939 Death is said to have occurred on the date stated above, at 6:30 a.m.
The principal cause of death and related causes of importance were as follows:

Tularemia
Date of onset 5/26/39
44

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 Ang D Callaway, M. D.
(Signed) Springfield Mo (Address)

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.

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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.

X