

JUL 11 1939

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

H. Knapp
22147
Do not use this space.

1. PLACE OF DEATH
(a) County GREENE Registration District No. 376
(b) Township _____ Primary Registration District No. 2001 Registered No. 507
(c) City SPRINGFIELD (d) Street No. Burge 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 Fred Walter Saunders
(a) Residence, No. 2421 Howard 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 15, 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
79 0 6

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

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) St. Augustine, Texas

13. NAME Fred W Saunders

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

15. MAIDEN NAME Ware

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 21, 1939

22. I HEREBY CERTIFY that I attended deceased from 6-15-1939 to 6-21-1939
I last saw him alive on 6-20-1939 Death is said to have occurred on the date stated above, at 3:30 A.M.
The principal cause of death and related causes of importance were as follows:
Congestive Lobular Pneumonia Date of onset 10/6

contributory cause of importance Chronic Bronchitis, Malnutrition, etc.

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) Henry F. French M. D.
(Address) 450 1/2 E. Conit St.

17. INFORMANT (ADDRESS) Mary J. Gates
2421 Howard

18. BURIAL, CREMATION, OR REMOVAL
PLACE Greenlawn DATE June 23, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alvin Schmege
Springfield Mo

20. FILED June 22, 1939 Chris A. Higgins Local Registrar

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. 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.....

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