

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.

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

29131
Do not use this space.

REC'D SEP 12 1939

1. PLACE OF DEATH

(a) County GREENE Registration District No. 316
 (b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 613
 (c) City SPRINGFIELD (d) Street No. Burgess 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. How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME REX - LEON - ANIKROM
 (a) Residence, No. Route 4 Box 199A 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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 5, 1939

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

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant
 9. Industry or business in which work was done, as saw mill, bank, etc. Infant
 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) Massena

FATHER

13. NAME Paul Arthur Anikrom
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Virginia

MOTHER

15. MAIDEN NAME Louise Marie Jump
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT Paul Arthur Anikrom
 (ADDRESS) Route 4 Box 199A

18. BURIAL, CREMATION, OR REMOVAL PLACE Burned away DATE Aug 6, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. W. Lingner & Co.
290 (Address) Springfield, Mo.

20. FILED Aug 6 1939 Chas. A. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 5, 1939

22. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 .

I last saw alive on , 19 . Death is said to have occurred on the date stated above, at 12 Noon

The principal cause of death and related causes of importance were as follows:
Stillborn - Prematurity (Compromised cord)

Date of onset

Other contributory causes of importance:
3 to 4 weeks premature

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?
 If so, specify No
 (Signed) H. E. Hagan M. D.
 (Address) Springfield, Mo.

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.

Paul E. Embalmer
..... 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