

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29169
State File No. _____
Registrar's No. **652**

SEP 12 1939
Registration District No. **518**

Primary Registration District No. **2001**

1. PLACE OF DEATH: **2**
(a) County Green
(b) City or town Springfield Missouri
(c) Name of hospital or institution _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Henry M East 230
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Rebecca M East
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 28 1866
(Month) (Day) (Year)

8. AGE: Years 74 Months 7 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace: Webster Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business _____

MOTHER FATHER
12. Name Thomas B. East
13. Birthplace Tenn
(City, town, or county) (State or foreign country)
14. Maiden name Mary E Shields
15. Birthplace Webster Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. W. Klingner
(b) Address 705 Cleveland

17. (a) Burial (b) Date thereof Aug 24 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation East Lawn

18. (a) Signature of funeral director J. W. Klingner
(b) Address 424 E. Springfield

19. (a) Aug 24 1939 (b) Chas. H. George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State mo (b) County Green
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. Cleveland 705
(If rural, give location)
(e) If foreign born, how long in U. S. A.? no years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 22 year 1939 hour 3 minute P.M.

21. I hereby certify that I attended the deceased from July 10, 1938 to Aug 22, 1939; that I last saw him alive on Aug 22, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure Duration _____

Due to Bright's Disease of Kidneys 2 years

Due to _____

Other conditions (Include pregnancy within 3 months of death) 171

Major findings: Of operations none
Of autopsy no

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? no (Specify type of place) (e) Means of injury none
Signature J. W. Klingner (M. D. or other) _____
Address 610 Woodruff Bldg Date signed Aug 23

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. 232
working under my personal supervision.

Signed Roy A. Baum
Licensed Embalmer No. 1763
P. O. Address Springfield

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.