1891 REC'D SEP 1 1939

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

30458
Do not use this space.

1. PLACE OF DEATH
(a) County Vernon
(b) Township Washington
or
(c) City Nevada
Registration District No. 875
Primary Registration District No. 6162
Registered No. 206
(d) Street No. State Hospital #3 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 5211 William Samuel Singleton
(a) Residence, No. 726 So Lexington Springfield St.
(Usual place of abode, if no street address, write county of city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 2-28-1864

7. AGE: Years 75 | Months 5 | Days 18 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Railroad
9. Industry or business in which work was done, as saw mill, bank, etc.: Laborer
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): Kentucky

FATHER
13. NAME: Garland Singleton
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

MOTHER
15. MAIDEN NAME: Elizabeth Swinney
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

17. INFORMANT (ADDRESS): Hospital Records

18. BURIAL, CREMATION, OR REMOVAL
PLACE Springfield Mo. DATE August 17, 1939

19. FUNERAL DIRECTOR (NAME) F. C. Shinn
(ADDRESS) Springfield, Mo.

20. FILED Aug 15, 1939 Allen V. Hays
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-15, 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-25, 1939, to 8-15, 1939
I last saw h. l. M. alive on 8-15, 1939. Death is said to have occurred on the date stated above, at 8:30 Am.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	
Other contributory causes of importance: Fracture Left Femur (Intertrochanteric)	7-10-39

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 .....
(Signed) F. C. Long M.D., M. D.
(Address) State Hosp #3 Nevada 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.

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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 Ralph Thieme, Registered Apprentice No. ....., working under my personal supervision.

Signed Ralph Thieme

Licensed Embalmer No. 3681

P. O. Address Springfield, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.

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

30458
Do not use this space.

1. PLACE OF DEATH
(a) County Vernon Registration District No. 875
(b) Township Washington Primary Registration District No. 6162 Registered No.
(c) City (d) Street No. #D 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 Wm Samuel Singleton
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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.
75	2	18	

OCCUPATION
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
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 19
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8 - 15 , 1939

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19
I last saw h alive on 19 Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:
Chronic Myo Carditis
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Date of onset

Other contributory causes of importance:
Fracture Left Femur
Inter trochanteric

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? Accident Date of injury 7-10, 1939
Where did injury occur? On Ward of State Hosp #3
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
State Hosp #3 Nevada Mo.
Manner of injury Fall to the floor from a standing position
Nature of injury Fracture of Left Femur Intertrochanteric

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) F C Long , M. D.
(Address) State Hosp #3 Nevada Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-30458