

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36115**

Registration District No. **321**

Primary Registration District No. **5444**

Registrar's No. **80**

1. PLACE OF DEATH:

(a) County **Greene**
(b) City or town **Rural**
(c) Name of hospital or institution: **Springfield Route # 3**
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**
(c) City or town **Rural**
(d) Street No. **Route # 3 Springfield, Mo.**
(e) If foreign born, how long in U. S. A? _____ years.

In this community _____ years, months or days

3. (a) PRINT FULL NAME **HAMILTON M^c CLURE 246**

8. (b) If veteran, name war _____ 8. (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 **Nethie M^c Clure** 6. (c) Age of husband or wife if alive **(?) 50** years

7. Birth date of deceased **No Record**

8. AGE: Years **Approx. 85** Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace **No Record** **Arkansas**

10. Usual occupation **Farmer**

11. Industry or business **Farming**

12. Name **No Record**

13. Birthplace **No Record**

14. Maiden name **No Record**

15. Birthplace **No Record**

16. (a) Informant's own signature **Nethie McClure**

(b) Address **Springfield Route # 3**

17. (a) **Burial** (b) Date thereof **Oct. 15, 1939**

(c) Place: burial or cremation **Lee Cemetery in Greene Co.**

18. (a) Signature of funeral director **F. C. Thieme**

(b) Address **Springfield, Mo.**

19. (a) **Oct. 23, 1939** (b) **Paul Hughes Mitchell**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **14th** year **1939** hour **5⁰⁰** minute **50** A.M.

21. I hereby certify that I attended the deceased from **Oct 10**, 1939, to **Oct 14**, 1939; that I last saw him alive on **Oct 14**, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial Pneumonia**

Due to **Bronchial Pneumonia**

Other conditions **NO**

Major findings: Of operations **NO**

Of autopsy **NO**

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

(a) Accident, suicide, or homicide (specify) **NO**

(b) Date of occurrence **NO**

(c) Where did injury occur? **NO**

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **NO**

While at work? **NO** (Specify type of place) (e) Means of injury **NO**

23. Signature **W F Kerr** (M. D. or other) Address **612 Woodruff Bldg** Date signed **Oct 15**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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.

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.