

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 218

Primary Registration District No. 2001 5439

1. PLACE OF DEATH: Yoss  
(a) County Greene  
(b) City or town Rural, N. Camp, Bldg. 1, 1/2  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Greene County Farm Hospital 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution less than a week  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Aubert Lee CAVE 15th  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. 500-01-3301

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Inez Cave 6. (c) Age of husband or wife if alive 33 years  
7. Birth date of deceased August 19 1893  
(Month) (Day) (Year)

8. AGE: Years 46 Months 2 Days 29  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Clifton Hill, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Mechanic

11. Industry or business w. P. A.

MOTHER FATHER  
12. Name Silas J. Cave  
13. Birthplace Cassville, Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Maggie Brummitt  
15. Birthplace Union, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wm. Cave  
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Nov. 20 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director H. C. Williams  
(b) Address Springfield, Mo.

19. (a) 11-20-39 (b) Chas. O. George M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1  
(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 880 N. Campbell  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 18th  
year 1939 hour 5 minute 10 P.M.  
21. I hereby certify that I attended the deceased from 11-14  
1939 to 11-18, 1939  
that I last saw him alive on 11-18, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, Lobar Duration 1 WK.  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 17 D

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_ (Specify type of place)  
(d) Means of injury \_\_\_\_\_  
23. Signature E. C. Mullinix (M. D. or other) M.D.  
Address Springfield, Mo. Date signed 11/22/39

**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.....

*Self*....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Ralph Thiene*.....  
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 comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

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