

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

43401

Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 316
 (b) Township 1 Primary Registration District No. 2001 Registered No. 933
 (c) City SPRINGFIELD (d) Street No. 2133 S. Douglas 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

(a) Residence, No. 1033 - S. Douglas 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

MEDICAL CERTIFICATE OF DEATH

3. SEX M
 4. COLOR OR RACE negro
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unkn. 1887
 7. AGE YEARS About 52 MONTHS unknown DAYS unknown
 If LESS than 1 day, hrs. or min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/25 1939
 22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 I last saw him dead on 12-25, 1939. Death is said to have occurred on the date stated above, at 3 P. m.
 The principal cause of death and related causes of importance were as follows:

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. laborer
 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

Acute Alcoholism
 Date of onset 12-3
 Other contributory causes of importance:
 Name of operation..... Date of.....
 What test confirmed diagnosis clinical Was there an autopsy?.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield Mo

FATHER
 13. NAME Joe Higgs
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Barry County Mo

MOTHER
 15. MAIDEN NAME Katharine Eslinger
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Strafford Mo

17. INFORMANT (ADDRESS) Joan Higgs 1024 Sherman

18. BURIAL, CREMATION, OR REMOVAL PLACE National Cemetery - 12-28-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. Y. Smith 702 - N. Jefferson

20. FILED 12/26 1939 Chas. R. George M.D. Local Registrar.

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no 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) Robert White M. D.
Lawrence Bruce M. D.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PREVIOUS status should be stated. 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.....

H. V. Smith....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *H. V. Smith*.....

Licensed Embalmer No. *3324*

P. O. Address..... *702 N. Jefferson*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

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

X