

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

2343
 Do not use this space.

FILED FEB 13 1940

1. PLACE OF DEATH
 (a) County..... **GREENE** Registration District No. **316**
 (b) Township..... Primary Registration District No. **20019** Registered No. **5**
 (c) City..... **SPRINGFIELD** (d) Street No. **St. Johns Hospital** 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. **9 ds** (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME **Blair Dwight Squibb**
 (a) Residence, No. **Bois D Arc No. 1010** St. **Bois D Arc Mo.**
 (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 **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF **Maudie M. Squibb**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 11 1875**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
↓	64	7	22	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Domestic**
 9. Industry or business in which work was done, as saw mill, bank, etc. **Private Practice**
 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) **Green County Mo.**

FATHER
 13. NAME **Joseph D. Squibb**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Raytown Greene**

MOTHER
 15. MAIDEN NAME **Sarah Leaper**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Greene County Mo.**

17. INFORMANT (ADDRESS) **Maudie M. Squibb Bois D Arc**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Clearcreek** DATE **Jan 7 1940**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Howard T. Sullivan Springfield Mo.**

20. FILED **1-3-** 19 **40** **Chas. A. George MD** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan 3 1940**

22. I HEREBY CERTIFY That I attended deceased from **12-27 1939** to **1-3 1940**

I last saw him alive on **12-27 1939** Death is said to have occurred on the date stated above, at **9:45 a.m.**

The principal cause of death and related causes of importance were as follows:
Murder

Date of onset

Other contributory causes of importance:
Adenocarcinoma of prostate gland, kidney stone

Name of operation **NONE** 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?..... 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? **N**
 If so, specify.....
 (Signed) **W. H. Engle**, M. D.
 (Address) **Springfield Mo.**

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.