

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.

JAN 23 1940

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

2368  
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 318

(b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 31

(c) City SPRINGFIELD (d) Street No. 1009 W Florida St. Florida

(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 200 RALPH BARTON MACK

(a) Residence, No. 1009 W Florida St.  (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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 17-1906

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
<u>33</u>	<u>3</u>	<u>22</u>	

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

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) Springfield Mo.

FATHER

13. NAME Charles Everett Mack

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

MOTHER

15. MAIDEN NAME Maudie Toland

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Roscoe Ohio

17. INFORMANT (ADDRESS) Mrs Maudie King 1009 W. Florida

18. BURIAL, CREMATION, OR REMOVAL PLACE Hazelwood DATE 1-11-1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm General Moore Springfield Mo

20. FILED 1-11-1940 Chas. A. George Mo Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 9, 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1940, to Jan 9, 1940. I last saw him alive on Jan 9, 1940. Death is said to have occurred on the date stated above, at 7:55 pm. The principal cause of death and related causes of importance were as follows:

<p align="center"><u>Diabetes Mellitus (Coma)</u></p> <p align="center"><u>Acidosis</u></p> <p align="center"><u>Chronic nephritis</u></p> <p align="center">Other contributory causes of importance: <u>5A</u></p>	<p>Date of onset</p>
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Name of operation None 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) J. Newton Wakeman, M. D. (Address) Springfield, Mo.

**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

*Ray W. Fox*

Licensed Embalmer No. *2910*

P. O. Address *629 W Walnut*

**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.**

X