

FILED FEB 13 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH2412
Do not use this space.

1. PLACE OF DEATH

(a) County GREENERegistration District No. 318(b) Township SPRINGFIELDPrimary Registration District No. 2001Registered No. 82(c) City SPRINGFIELD(d) Street No. Burge 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

(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 512 NICK JOSEPH GINGER St. R-8 Springfield 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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

MWBaby

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

Nov - 12 - 1939

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

0213

OCCUPATION

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

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

Child

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

Springfield Mo

FATHER

13. NAME

Clyde C Ginger

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

Christian Co Mo

MOTHER

15. MAIDEN NAME

Bernice Kubdlawski

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

Mo

17. INFORMANT (ADDRESS)

Clyde C Ginger R-8 Springfield Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE McConnellDATE 1-28

1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

Wunn Springfield Mo20. FILED 1-27

1940

Chas. A. George(Address) Springfield Mo

Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

Jan 26 1940

22. I HEREBY CERTIFY, That I attended deceased from

1-23, 1940, to 1-26-40, 1940I last saw him alive on 1-25-40, 1940. Death is saidto have occurred on the date stated above, at 1:20 p.m.

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

Date of onset

Influenza1-22-40

Other contributory causes of importance:

Pneumonia, bronchial1-24-40Persistent otitis media1-23-40

Name of operation

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

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? no

If so, specify

(Signed)

Chas. A. George

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.....

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.

X