

o. 2
-10-39
7-39
X21492
ED MAY

call 8 - when completed

Lee Hall
14889
State File No. _____
Registrar's No. 349

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 318

Primary Registration District No. 2001

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Bremer
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Springfield Baptist Hospital
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution 3 hours
(Specify whether
In this community _____
years, months or days) 11 E 6

3. (a) PRINT FULL NAME FRED F. DELAND
(b) If veteran, name war No (c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Clara E. De Land 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased July 12 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 8 27 hr. min.

9. Birthplace Clinton Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business
12. Name Delmar De Land
13. Birthplace Vermont
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Smith
15. Birthplace Massachusetts
(City, town, or county) (State or foreign country)

16. (a) Informant Wilma Wilton
(b) Address Council Bluffs, Iowa
17. (a) Burial (b) Date thereof April 12 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Council Bluffs, Iowa

18. (a) Signature of funeral director F. C. Williams
(b) Address Springfield, Mo.
19. (a) 4/11/40 (b) Chas. A. George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Taney
(c) City or town Ridgedale
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 9th
year 1940 hour 9:30 minute _____ P. M.
21. I hereby certify that I attended the deceased from 4/9/40
to 4/9/40, 19 40
that I last saw h. IM alive on 4/9/40, 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral arteriosclerosis
(Alzheimer disease)
Due to Dehydration
Due to Senility
Other conditions (include pregnancy within 3 months of death) AM

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?
2610 (Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature Dwight K. Hall (M. D. or other) _____
Address 500 Shellwood Bldg Date signed 4/11/40

(Licensed Embalmer's Statement on Reverse Side) 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.....

R. H. Thomas

Licensed Embalmer No.....

3487

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.