

MAY 13 1940

318

State File No.

355

Registration District No.

Primary Registration District No. 2001

Registrar's No.

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution
633 N. GRANT
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days 6; 76

3. (a) PRINT FULL NAME GEORGE W. HANDLER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 10 1888
(Month) (Day) (Year)

8. AGE: Years 54 Months 9 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Carpenter

11. Industry or business Construction

12. Name Thomas L. Chandler

13. Birthplace Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Livona Graves

15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature T. L. Chandler

(b) Address Springfield Mo.

17. (a) Burial (b) Date thereof April 14-1940
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty Cemetery

18. (a) Signature of funeral director L. W. Blumauer & Co.

(b) Address Springfield Mo.

19. (a) 4/13/40 (b) Oliver H. George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Springfield
633 N. Grant
(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 12th
year 1940 hour 10 minute 30 A. M.

21. I hereby certify that I attended the deceased from 3-27-40 to 4/12, 1940

that I last saw him alive on 4/12, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death acute myocarditis following Influenza

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death) 11 P

Major findings: Of operations _____

Of autopsy _____

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? 295
While at work? _____ (Specify type of place)
(a) Means of injury _____

23. Signature C. E. Feller (M. D. or other) _____
Address Springfield Mo. Date signed 4/12/40

PHYSICIAN

Underline the cause to which death should be charged statistically

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.....

Ogle Sloan

Registered Apprentice No. *232*

working under my personal supervision.

+

Signed.....

J. B. Klingner

Licensed Embalmer No. *3358*

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.

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