DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Dr. Wakeman

State File No. 14935

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 398

1. PLACE OF DEATH:

(a) County: GREENE

(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Burge
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 2 days (Specify whether years, months or days)

In this community: 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene

(c) City or town: Springfield
(If outside city or town limits, write "RURAL")

(d) Street No.: 226 W. Madison
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: James Oliver Housh

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: Married

6. (b) Name of husband or wife: Edith Housh

6. (c) Age of husband or wife if alive: ____ years

7. Birth date of deceased: Sept (Month) 12 (Day) 1867 (Year)

8. AGE: Years 72 | Months 7 | Days 16 | If less than one day: ____ hr. ____ min.

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

10. Usual occupation: Retired Barber

11. Industry or business: ?

FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant's own signature: Mrs. Mildred Phillip
(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 3 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: EAST LAWN

18. (a) Signature of funeral director: H. H. Lohmeyer
(b) Address: Springfield, Mo.

19. (a) 5-1-40 (Date received local registrar) (b) W. E. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28 year 1940 hour 5 minute 40 p. M.

21. I hereby certify that I attended the deceased from Apr 20, 1940, to Apr 28, 1940; that I last saw him alive on Apr 27, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Nephritis a	1 year
Generalized Edema Ascites	
Due to:	
Due to: Diabetes Mellitus	3 yrs.
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: None	
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): None

(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? ____ (Specify type of place)

While at work? ____ (e) Means of injury: ____

23. Signature: Newton Wakeman (M. D. or other)

Address: Springfield Mo. Date signed 4-29-40

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imp

PERMANENT RECORD

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.