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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JUN 13 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18409

Registration District No. 318 — Primary Registration District No. 2001 — Registrar's No. 428

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

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: 624 Poplar 2 (If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene

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

(d) Street No. 624 Poplar (If rural, give location)

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

3. (a) PRINT FULL NAME JOHN W. OTT. 300

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 Sep (Month) 8 (Day) 1858 (Year)

8. AGE: Years 81 Months 7 Days 29 If less than one day hr. min.

9. Birthplace Haggerstown (City, town, or county) Md. (State or foreign country) 1

10. Usual occupation Retired Boilermaker

11. Industry or business R. R. Shops

FATHER
12. Name Jacob D. Ott
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Mrs. George E. Shane
(b) Address Springfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation East Lawn

18. (a) Signature of funeral director J. W. Klingner & Co.
(b) Address Springfield Mo.

19. (a) May 9, 1940 (Date received local registrar) (b) W. E. Handley M.D. (Registrar's signature) RFB

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7 year 1940 hour 5 minute 10 A M.

21. I hereby certify that I attended the deceased from April 5, 1940 to May 7, 1940 that I last saw him alive on May 7, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Bright Disease of Kidneys

Due to (Chr Interstitial Nephritis)

Due to

Other conditions (Include pregnancy within 3 months of death) 131

Major findings:
Of operations no
Of autopsy no

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: no
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? no (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 9 C/U (Specify type of place)
While at work? (e) Means of injury

23. Signature U F Kerr (M. D. or other) 1
Address 610 Woodruff Bldg Date signed May 7

(Licensed Embalmer's Statement on Reverse Side)

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 Slone Jr. #232, Registered Apprentice No. #232 working under my personal supervision.

Signed William Max Rhod

Licensed Embalmer No. 4071

P. O. Address Spring Juli

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.