

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: **2031 N. MISSOURI 2**
 (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 **12 11**

3. (a) PRINT FULL NAME **JOSIAH DOOLITTLE**
3. (b) If veteran, _____ **3. (c) Social Security** _____
 name war _____ 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 **March 7-1850**
 (Month) (Day) (Year)

8. AGE: Years **98** Months **2** Days **9** If less than one day _____ hr. _____ min.

9. Birthplace **Pawnee Ill. 1**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Retired (10 yr.) Farmer**

11. Industry or business **Farming**

12. Name **Edwin Doolittle**
13. Birthplace **Unknown New York 1**
 (City, town, or county) (State or foreign country)

14. Maiden name **Emeline Cooper**
15. Birthplace **Unknown N.Y. 1**
 (City, town, or county) (State or foreign country)

16. (a) Informant **John W. Doolittle**
(b) Address **2031 N. Mo. Ave.**

17. (a) Burial **(b) Date thereof** **May 17-1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **J. W. Ringner Co.**
(b) Address **Springfield, Mo.**

19. (a) May 17, 1940 **W. E. Handley MD**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Greene**
 (c) City or town **Springfield, Mo.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **2031 N. Missouri**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **16th** day **May**
 year **1940** hour **9** minute **45** A.M.
21. I hereby certify that I attended the deceased from **Past 4 years**
 _____, 19____, to **May 16, 1940**
 that I last saw him alive on **May 15, 1940**
 and that death occurred on the date and hour stated above.

Immediate cause of death
Neurosis of Stomach
 Due to _____
Due to **Carcinoma of Stomach - Gastric**
 Other conditions _____
 (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations **H/O**
Of autopsy _____
 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? _____
 While at work _____ (Specify type of place) _____ Means of injury _____
Signature **Shelburne W. Vogel MD** (M.D. or other) **3**
Address **Springfield, Mo.** **Date signed** **May 17, 1940**

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.

William Paul [Signature]
4071
Springfield [Signature]
+