

Registration District No. 316

Primary Registration District No. 5440

Registrar's No. 453

39

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

1. PLACE OF DEATH:

(a) County GREENE S Campbell To
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Route # 8
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limit write "RURAL")
(d) Street No. Route # 8
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME John P. Kreider 636

8. (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 Mary V. Kreider 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 12 1866
(Month) (Day) (Year)

8. AGE: Years 74 Months 3 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name John P. Kreider

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

14. Maiden name Flinda Porter

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

16. (a) Informant Mary V. Kreider

(b) Address Route # 8 Springfield, Mo.

17. (a) Burial (b) Date thereof May 22 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood

18. (a) Signature of funeral director H. H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) May 20, 1940 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10
year 1940 hour 7 minute 40 P. M.

21. I hereby certify that I attended the deceased from Jan 10 - 29
_____ 19____, to May 19 19____;
that I last saw him alive on May 14 19____
and that death occurred on the date and hour stated above.

Immediate cause of death
Tuberculosis
(Pulmonary)

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

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? _____

23. Signature W. E. Handley MD (M. D. or other) _____
Address Springfield Mo Date signed May 20 1940

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

X

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.

X