

Registration District No. 315

Primary Registration District No. 2001

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: 755 Normal 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) 245

3. (a) PRINT FULL NAME Perry Hory M^s Lean

3. (b) If veteran, name war NO 3. (c) Social Security No. None.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Jens M^s Lean 6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased October 2, 1841
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>98</u>	<u>10</u>	<u>18</u>	hr. _____ min. _____

9. Birthplace Unknown West Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Unknown M^s Lean

18. Birthplace Unknown Scotland 4
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant John T. M^s Lean
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 8-23-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Akron, Ohio AG 4

18. (a) Signature of funeral director Alma Johnson
(b) Address Springfield, Mo.

19. (a) Aug 23 1940 (b) W. E. Hurdley
(Date received local registrar) (Registrar's signature)

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. 755 Normal
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 20
year 1940 hour 8:30 minute A. M.

21. I hereby certify that I attended the deceased from Aug 18-1940
_____ 19 _____ to Aug 20, 1940
that I last saw him alive on Aug 19, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____ 3 days

Due to _____ g.w.

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

Major findings: Of operations _____

Of autopsy _____

Duration
3 days

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) _____

(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 _____

Signature J. S. Bruton (M. D. or other) _____
Address Springfield Mo Date signed 8/20/40

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

MOTHER FATHER

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

Harlow Knabb

Licensed Embalmer No. *4065*

P. O. Address *Springfield Mo*

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.