

Registration District No. 316  
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: 1924 N. Howard  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 20  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME William E. Varley  
3. (b) If veteran, name war no  
3. (c) Social Security No. no

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Josephine Varley  
6. (c) Age of husband or wife if alive Unknown years  
7. Birth date of deceased August 12 1863  
(Month) (Day) (Year)

8. AGE: Years 77 Months 1 Days 25  
If less than one day hr. min.

9. Birthplace Mary County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Frisco Shopman  
11. Industry or business Frisco R.R.

12. Name Unknown  
13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Josephine Varley  
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Oct. 9 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary Cem.  
18. (a) Signature of funeral director H.H. Lohmeyer  
(b) Address Springfield, Mo.

19. (a) 10-9-40 (b) W.E. Haudley M.D.  
(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. 1924 N. Howard  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7  
year 1940 hour 7 minute 20 a.m.

21. I hereby certify that I attended the deceased from 10-4-40, 1940, to 10-7-40, 1940  
that I last saw him alive on 10-4-40, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Cerebral Palsy  
Hemiplegia

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
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? \_\_\_\_\_

(e) While at work? \_\_\_\_\_ (Specify type of place)  
(f) Means of injury \_\_\_\_\_

23. Signature W. Kelly (M. D. or other)  
Address Springfield, Mo. Date signed 10-9-40

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

MOTHER FATHER

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**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, fact should be so stated above.**