

No. 2
13-40
17-39
X23139

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35312

State File No.

Registrar's No.

Registration District No. 318

Primary Registration District No. 2001

829

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: St. John's Hospital
 (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

3. (a) PRINT FULL NAME Robert L. Workman

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 Married

6. (b) Name of husband or wife Alice Workman 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased April 6 1881
(Month) (Day) (Year)

8. AGE: Years 59 Months 6 Days 4 If less than one day
 hr. _____ min. _____

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

10. Usual occupation Real Estate

11. Industry or business Agent

12. Name John Workman

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

14. Maiden name Lizzie Rice

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

16. (a) Informant Mrs. Alice Workman

(b) Address Springfield Mo.

17. (a) Burial (b) Date thereof Oct. 12 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation San Antonio, Texas

18. (a) Signature of funeral director Alma Johnson

(b) Address Springfield Mo.

19. (a) Oct. 12, 1940 (b) W.E. Handley MD
(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. Metropolitan Hotel
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 10
year 1940 hour 4 minute 7 M.

21. I hereby certify that I attended the deceased from August 28, 1940, to Oct. 10, 1940, that I last saw him alive on October 9, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Deep peracute Pyo nephritis Duration 3 WKS

Due to Metastatic Papillary carcinoma

Due to Papillary Carcinoma Rt Kidney (Removed 2 yrs ago) primary 51

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

Major findings: Single 2 dehydrated kidney (nephrectomy drainage)

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? ACU

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Steedman (M. D. certifier) 1

Address Springfield Mo Date signed 10/10/40

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

FILED NOV 12 1940

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.....

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.

X