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21492

Registration District No. 318 NOV 12 1940

Primary Registration District No. 5439

Registrar's No. 803

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: CO. ALMS HOUSE
(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 MO

(b) County Greene

(c) City or town Springfield
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME PIERCE LOWE

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 single

6. (b) Name of husband or wife None

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1
year 1940 hour 3 minute 00 P.M.

21. I hereby certify that I attended the deceased from Feb.
1, 1939, to Oct. 1, 1940
that I last saw him alive on Sept. 25, 1940
and that death occurred on the date and hour stated above.

8. AGE: Years about 58 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business Miscellaneous

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)

Immediate cause of death Myocarditis, Chronic

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

MOTHER FATHER

16. (a) Informant J. J. Hixson

(b) Address R. 4 Springfield, Mo

17. (a) Burial (b) Date thereof Oct 4 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cemetery

18. (a) Signature of funeral director G. W. Klingner & Co.

(b) Address Springfield, Mo

19. (a) 10-4-40 (b) W. E. Handley, M.D.
(Date received local registrar) (Registrar's signature)

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature E. C. McMillin, M.D. (M. D. or other) _____

Address Springfield, Mo Date signed 10/1/40

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

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 J. B. Klingner
Licensed Embalmer No. 3358
P. O. Address Springfield,

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.