

Registration District No. **318**

Primary Registration District No. **2001**

Registrar's No. **176**

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: **Springfield Baptist Hospital** **O**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **hospital 1 week**
(Specify whether)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME **Legan, ~~Miss~~ Billy Ray**
 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. (c) Age of husband or wife if alive **XX** years
 7. Birth date of deceased **February 5 1930**
(Month) (Day) (Year)

8. AGE: Years **11** Months **0** Days **23**
If less than one day hr. min.

9. Birthplace **Bellevue Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Child**
 11. Industry or business _____

MOTHER FATHER
 12. Name **William P Legan**
 13. Birthplace **Wanglane Mo**
(City, town, or county) (State or foreign country)
 14. Maiden name **Laura Lucille Kerr**
 15. Birthplace **Pleasant Hope Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mother**
 (b) Address **Pleasant Hope, Mo**
 17. (a) **Burial** (b) Date thereof **March 2 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Pleasant Hope Mo**

18. (a) Signature of funeral director **Hutcherson Funeral Home**
 (b) Address **Bellevue Mo**
 19. (a) **3-2-41** (b) **A. W. Hutcherson**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Polk** **84**
 (c) City or town **Pleasant Hope** **O**
(If outside city or town limits, write "RURAL") **Rural**
 (d) Street No. _____
(If rural, give location) **1**
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Feb** day **28**
 year **1941** hour **6** minutes **30 P.** M.

21. I hereby certify that I attended the deceased from **Feb 21** 19**41** to **Feb 28** 19**41**;
 that I last saw him alive on **Feb 28** 19**41**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Smear Peritonitis**
 Due to **Ruptured Spleen**
 Due to **Appendix**
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____
 12/1/41

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. H. Smith** (M. D. or other) **MD**
 Address **Springfield, Mo** Date signed _____
(Specify type of place) (c) Manner of injury

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

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

39
2
6

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.

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