

APR 10 1941 318

Primary Registration District No. 2001

Registrar's No. 246

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 Hosp.
(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 Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 824 S. Jefferson
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24
year 1941 hour 3 minute p. M.

21. I hereby certify that I attended the deceased from March 24, 1941, to March 24, 1941;
that I last saw him alive on March 24, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity 5 mos
Due to Cause Unknown

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

Major findings: _____
Of operations _____
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? _____

While at work _____ (Specify type of place) _____
(c) Means of injury _____
23. Signature Joseph L. Johnston MD
Address Springfield, Mo Date signed 3-25-41

39

2

6

1

0

years.

24

3

p.

March 24

March 24

March 24

19 41

Duration

5 mos

Cause Unknown

154

PHYSICIAN

Underline the cause to which death should be charged statistically.

Of operations

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?

While at work

(Specify type of place)

(c) Means of injury

23. Signature

Address

Date signed

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

9
2
6

3. (a) PRINT Infant Son of
FULL NAME Mr. Mrs. E.G. Covell

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 Single

6. (b) Name of husband or wife Inf. 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased: March (Month) 24 (Day) 1941 (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day hr. 15 min.

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

10. Usual occupation Inf.

11. Industry or business _____

12. Name E.G. Covell

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

14. Maiden name Lynas S. Spanbauer

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

16. (a) Informant E.G. Covell

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof March 25 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eastlawn

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 3-25-41 (b) W.E. Handley MD
(Date received local registrar) (Registrar's signature)

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.