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DEC 15 1941

State File No. \_\_\_\_\_  
Registrar's No. 918

Registration District No. 318

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: St. Johns Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
(Specify whether  
In this community 4 days  
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. 615 W. Lynn  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Rolland Lee Wilson

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased November 18, 1941  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 4 If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name Clyde Wilson  
13. Birthplace Christian County, Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Ada Hancock  
15. Birthplace Unknown South Dakota  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Clyde Wilson  
(b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof 11-24-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Eastlawn Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home  
(b) Address Springfield, Missouri  
(c) While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

19. (a) 11-24-41 (b) W. E. Handley MD  
(Date received local registrar) (Registrar's signature)  
20. Signature Engel Schwartz (M. D. or other)  
Address Med. Arts Bldg. Springfield Date signed 11-24-41

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22  
year 1941 hour 4:18 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from 11-19-41  
to 11-22-41  
that I last saw him alive on 11-22-41  
and that death occurred on the date and hour stated above.

Immediate cause of death: Esophyloblastosis foetalis (Congenital Atresia)  
Duration 4 days

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 1610

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

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

MOTHER FATHER

984

**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 *This Body Not Embalmed*

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.**