No. 2
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 13 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. Allder

State File No. 6684

Registration District No. 318 | Primary Registration District No. 2001 | Registrar's No. 156

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: 306 E. Chestnut / (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: About 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Greene 39
(c) City or town: Springfield 2 (If outside city or town limits, write "RURAL")
(d) Street No.: 306 E. Chestnut 6 (If rural, give location)
(e) Citizen of foreign country? Unknown (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Theodore Humbert
3. (b) If veteran, name war: no
3. (c) Social Security No.: no
4. Sex: Male 1
5. Color or race: White
6. (a) Single, widowed, married, divorced: Unknown 4
6. (b) Name of husband or wife: Unknown
6. (c) Age of husband or wife if alive: Unknown years
7. Birth date of deceased: Unknown (Month) Unknown (Day) Unknown (Year)
8. AGE: Years: About 82 | Months: Unknown | Days | If less than one day: ____ hr. ____ min.
9. Birthplace: Unknown (City, town, or county) France 5 (State or foreign country)
10. Usual occupation: Gardner
11. Industry or business: ____
FATHER 12. Name: Unknown
FATHER 13. Birthplace: Unknown (City, town, or county) Unknown 7 (State or foreign country)
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Unknown (City, town, or county) Unknown 7 (State or foreign country)
16. (a) Informant: Personal Papers
(b) Address: Springfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 28 1942 (Month) (Day) (Year)
(c) Place: burial or cremation: Hazelwood
18. (a) Signature of funeral director: H. H. Lohmeyer
(b) Address: Springfield, Mo.
19. (a) 2-28-42. (Date received local registrar) (b) L. W. Dandy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Feb. day: 26 year: 1942 hour: 2 minute: 45 p.m.
21. I hereby certify that I attended the deceased from 2/22/42, 19__, to 2/25/42, 19__; that I last saw him alive on 2/25/42, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Apoplexy	4 da.
Due to: Fall in floor 2/22/42	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: F. E. Allder (M. D. or other)
Address: Springfield, Mo. Date signed: 2/28/42

9 54 (Licensed Embalmer's Statement on Reverse Side)

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 Walter E Hamilton

Licensed Embalmer No. 3808

P. O. Address Springfield Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

X

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6684

Registration District No. 318 Primary Registration District No. 2001 Registrar's No.

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

SUPPLEMENTARY

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:
(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 (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Therodore Humbert
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced unk
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased unk (Month) (Day) (Year)

8. AGE: Years 82 Months — Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 26 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.
Immediate cause of death Apoplexy Fell in floor — Duration 4 da
Due to
Due to Apoplectic Stroke
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations 83a
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) — Accident?
(b) Date of occurrence 2/22/42
(c) Where did injury occur? Springfield (City or town) Home (County) Mo (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? No (c) Means of injury
23. Signature A. E. Allder (M. D. or other)
Address Springfield Date signed 4/6/42