2
-41
-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 3 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Dr. B. Meyer

State File No. 10816

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 224

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 873 South
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 40 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 039

(c) City or town Springfield 2
(If outside city or town limits, write "RURAL") 6

(d) Street No. 873 South
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Mollie E. Reddick

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Saml. M. Reddick

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

7. Birth date of deceased March (Month) 10 (Day) 1870 (Year)

8. AGE: Years 72 Months 0 Days 11 If less than one day hr. min.

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

10. Usual occupation Home

11. Industry or business

FATHER
12. Name A.R. Swearingin
13. Birthplace Unknown (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Tenn. (State or foreign country)

16. (a) Informant Mrs Clara Fahrney
(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 24 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 3-24-42 (Date received local registrar) (b) Dr W B Handley (Registrar's signature) 944

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21
year 1942 hour 5 minute 50 p.M.

21. I hereby certify that I attended the deceased from Jan. 1 1939, to Mar 21 1942
that I last saw him alive on March 21 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia
Renal Pauuring?

Due to

Due to

Other conditions Advanced Carcinoma of face & neck
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 53

Duration

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 0

23. Signature C. Burton Meyer (M. D. or other)
Address Springfield Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

MAR 26-42

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 the above constitutes grounds for revocation of license.)

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

o. 2B
-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10 816

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

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 Mollie E. Reddick

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

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

7. Birth date of deceased Mar (Month) 10 (Day) 1870 (Year)

8. AGE: Years 72 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 Mar day 21
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
Phenol Poisoning

Due to N.M.O.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Duration

Major findings:
Of operations

Of autopsy

1797
13

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
(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 C. Bertram Moyer (M. D. ~~or other~~)
Address 408 McDaniel Bldg Date signed 9-29-43

S-10816 1942