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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17949

State File No. _____

FILED JUN 10 1942

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 364

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

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 756 W. Pacific 1
(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

3. (a) PRINT FULL NAME WILLIAM ATWOOD

3. (b) If veteran, name war NONE

3. (c) Social Security No. 500-10-2516

4. Sex MALE

5. Color or race WHITE

6. (a) Single, married, divorced MARRIED

6. (b) Name of husband or wife LOIS ATWOOD

6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased Aug 11 1885
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>56</u>	<u>8</u>	<u>26</u>	hr. _____ min. _____

9. Birthplace Unknown mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business General Work

12. Name Preston Atwood

13. Birthplace Unknown Wis 1
(City, town, or county) (State or foreign country)

14. Maiden name Frances Stewart

15. Birthplace Unknown Ill. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Lois Atwood

(b) Address 756 W. Pacific Springfield Mo.

17. (a) Burial May 8-1942
(Burial, cremation, or removal) (Date thereof) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Hope Mo.

18. (a) Signature of funeral director W. H. Minger Mo.

(b) Address Springfield Mo.

19. (a) 5-8-42 W. S. Bradley
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene

(c) City or town Pleasant Hope 8 10 0
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7th
year 1942 hour 7 minute 00 P. M.

21. I hereby certify that I attended the deceased from May 5, 1942, to May 6, 1942,
that I last saw him alive on May 6, 1942,
and that death occurred on the date and hour stated above.

Immediate cause of death Metal laceration of left the heart

Due to _____

Due to _____

Other conditions Tuberculosis 4 yrs
(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?

While at work? (Specify type of place) _____
(e) Means of injury 0

23. Signature W. E. Althoff (M. D. or other) _____

Address 1128 N. Jefferson Date signed 5/7/42

WE 148 (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.....

Roy A. Leavin

Licensed Embalmer No.....

1763

P. O. Address.....

Springfield

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.

X

MISSOURI STATE BOARD OF HEALTH
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State File No. 17949

Registration District No. 318

Primary Registration District No. 2001

Registrar's No.

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)

3. (a) PRINT FULL NAME Will Atwood

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 m

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Aug 11 1885
(Month) (Day) (Year)

8. AGE: Years 56 Months 8 Days 25
(If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day _____
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

tuberculosis of
both lungs of

Due to _____

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) (e) Means of injury _____

23. Signature W. E. Albright (M. D. or other) _____
Address Springfield, Mo. Date signed _____

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

SUPPLEMENTARY

MENTALARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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سید محمد علی محمدی