

S. No. 2  
-1-4-41  
5-17-39  
PI X26320

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

21204

FILED JUL 16 1942

State File No. \_\_\_\_\_

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 423

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: BURGE HOSP. O  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 DAY  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County GREENE

(c) City or town SPRINGFIELD Rural  
(If outside city or town limits, write "RURAL" and name of township)

(d) Street No. R.F.D # 4  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CHARLES EDWARD LANE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2<sup>nd</sup>  
year 1942 hour 8 minute 15 A. M.

3. (b) If veteran, name war NONE 3. (c) Social Security No. 770

21. I hereby certify that I attended the deceased from 6-1-42 19 to 6-2-42 19  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased: Unknown 1869  
(Month) (Day) (Year)

Immediate cause of death: Acute Intestinal Obstruction Duration 18 hrs.

Chronic Dehydration 6 mo

8. AGE: Years Approx. 73 Months Unknown Days Unknown If less than one day Unknown  
hr. min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

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

Major findings: Of operations 1226

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

10. Usual occupation Retired

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

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Person Dept. Co. Hagan

(b) Address R. 50 Springfield, Mo.

17. (a) Burial (b) Date thereof June 29 1942  
(Burial, cremation, or removal) (Month) (Year)

(c) Place: burial or cremation Home

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? \_\_\_\_\_

18. (a) Signature of funeral director [Signature]

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Springfield Mo. Date signed 6/2/42

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

29  
5  
6

**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 *Ray Adams*  
Licensed Embalmer No. *1763*  
P. O. Address *Springfield Mo*  
*X*

**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.**