

Registration District No. 318

Primary Registration District No. 2000

Registrar's No. 635

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: O'Reilly General Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 44 days (Specify whether  
 In this community 44 days years, months or days)

3. (a) PRINT FULL NAME LEE (NONE) GENTRY

3. (b) If veteran, name war World War I 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, /divorced Married  
 6. (b) Name of husband or wife Mamie C. Gentry 6. (c) Age of husband or wife if alive Unknown years  
 7. Birth date of deceased March 13 1885  
 (Month) (Day) (Year)

8. AGE: Years 57 Months 5 Days 15 If less than one day hr. min.

9. Birthplace Asheville No. Carolina  
 (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Unknown

12. Name Unknown

13. Birthplace Asheville No. Carolina  
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown No. Carolina  
 (City, town, or county) (State or foreign country)

16. (a) Informant W.D., A.G.O. Forms #20 and #24

(b) Address

17. (a) Removal (b) Date thereof Aug. 28, 1942  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation San Antonio, Texas

18. (a) Signature of funeral director Fred P. Thorne

(b) Address 408 Boonville Ave Sfld Mo

19. (a) 8/28/42 (b) Date of death 8/28/42  
 (Date given for registration) (Date of death)

2. USUAL RESIDENCE OF DECEASED:

(a) State Texas (b) County Bexar 999  
 (c) City or town San Antonio 41  
 (If outside city or town limits, write "RURAL") 0  
 (d) Street No. 266 Felisa  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 28  
 year 1942 hour 12 minute 21 A.M.

21. I hereby certify that I attended the deceased from July 16, 1942  
 to August 28, 1942  
 that I last saw him alive on August 27, 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death Myeloma, multiple, 5 mos.  
involving the skull, 4th rib, left;  
7th rib, right, and 4th thoracic  
vertebra

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

Other conditions Anemia, simple, severe 2 mos  
 (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_

Of autopsy Confirmation of above  
diagnosis

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 Fred P. Thorne (M. D. or other) \_\_\_\_\_

Address O'Reilly San Antonio Date signed 8/28/42

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

39  
2  
6

#7

984

*Handwritten notes and signatures at the bottom right of the page.*

**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..... *Fred C. Thomas*.....

Licensed Embalmer No. *2899*

P. O. Address *Springfield, Mo.*

**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.**

Registration District No. 128

Primary Registration District No. 200

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:  
(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 Lee (name) Henry

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: ma 13 18  
(Month) (Day) (Year)

8. AGE: Years 57 Months 5 Days 7  
If less than one day in 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) 12-31-42 (b) E. W. Henry  
(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 Aug Day 28 Year 1942 Minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., that I last saw him....., 19....., and that death occurred on the date and hour stated above.

Immediate cause of death: myeloma multiple involving the skull, 4th rib such dist - 7th rib

Due to: right of 4th - thoracic vertebra

Due to: Primary seat - Undetermined

Other conditions: anemia, simple  
(Include pregnancy within 3 months of death)

Major findings: severe

Of operations: 57

Of autopsy: Confirmation of above diagnosis

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 W. E. Leedy, Cpt. M. D. (M. D. or other)  
O'Reilly Gen. Hosp. Date signed.....  
Address Springfield, Mo.

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

SUPPLEMENTARY

MOTHER FATHER

