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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33730

State File No.

Registrar's No. 588

FILED OCT 26 1942
Registration District No. 010

Primary Registration District No. 2000

39
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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: St Johns Hosp. City
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Days
15 Years (Specify whether years, months or days)

In this community 15 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 1535 E Florida
(If apart, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME William E. Humphery

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M

5. Color or race White

6. (a) Single, widowed, married, divorced 2 divorced Widowed

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive Dec. 22 1866 years (Day) (Year)

7. Birth date of deceased: Jan 22 1866
(Month) (Day) (Year)

8. AGE:

Years <u>76</u>	Months <u>6</u>	Days <u>17</u>	If less than one day
			hr. min.

9. Birthplace Mt. Vernon ILL
(City, town, or county) (State or foreign country)

10. Usual occupation R. D. Mail carrier

11. Industry or business

12. Name John Humphery

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

14. Maiden name Martha Dodson

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

16. (a) Informant Mrs. Amy Vess

(b) Address 513 W Kearney City

17. (a) Burial (b) Date thereof Aug 11 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Garfield, Ark. Dunn Funeral Home

18. (a) Signature of funeral director Springfield MO

(b) Address

19. (a) 8-10-42 (b) W. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9 th
year 1942 hour I. 30 minute P. M.

21. I hereby certify that I attended the deceased from Aug 28 1942 to Aug 9 1942
that I last saw him alive on Aug 9 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia 4 days

Due to Cardiac Failure Unknown

Due to

Other conditions Cerebral Hemorrhage 7 mos.
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: None

Of operations

Of autopsy None

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

23. Signature J. Davlin (M. D. or other)

Address Springfield, Mo. Date signed 8/10/42

784

OCT 26 1942

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

Laurence L. Hall

Licensed Embalmer No. *2784*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33730
Registrar's No. 6-88

Registration District No. 128 Primary Registration District No. 2000

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 Wm E. Humphery
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July year 1942 day _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I first saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Bronchial 4 days
Immediate cause of death: Pneumonia Hypertension

4. Sex M 5. Color 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: Jan 22 (Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days all 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 12-31-42 (b) D. M. Jaudy
(Date received local registrar) (Registrar's signature)

Due to Cardiac Failure unk

Due to _____

Other conditions: Cerebral Hemorrhage 2 mos.

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)
(b) 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 J. M. Sartain (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

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

