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FILED APR 28 1943

128

Primary Registration District No. 2000

Registrar's No. 285

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: 1917 N. GRANT AVE.
(If not in hospital or institution, write street number or location)

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

In this community 52 YR 7 MO. 28 DAYS. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County GREENE.

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

(d) Street No. 1917 No GRANT AVE.
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME PERRY H. MONDAY.

3. (b) If veteran, name war NONE

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 IDA B. MONDAY

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased AUG. 11 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

52 7 28 hr. min.

9. Birthplace GREENE CO. MO.
(City, town, or county) (State or foreign country)

10. Usual occupation BUS OPERATOR

11. Industry or business GAS & ELEC. CO. TRANSPORTATION

12. Name CHAS. MONDAY

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

14. Maiden name MARGARET M. TRANZHEM

15. Birthplace GREENE CO. MO.
(City, town, or county) (State or foreign country)

16. (a) Informant Ida Monday

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof April 14 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Robberson Prairie

18. (a) Signature of funeral director J. W. Klingner

(b) Address Springfield, Mo.

19. (a) 4-13-43 (b) B. W. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 9 year 1943 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 10 1942 to April 9 1943
that I last saw him on 4-9-43 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Neurophage Duration 3 hr

Due to chronic nephritis

Due to feeding three stomach tubes for 40 yrs.

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy no 1318

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) no

(b) Date of occurrence no

(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? no (Specify type of place)

(e) Means of Injury D

23. Signature J. F. Freeman (M. D. or other)

Address Springfield, Mo. Date signed 4/9/43

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

985

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.....

J. B. Klingner

Licensed Embalmer No.....

3358

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.