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FILED AUG 9 1943

Registration District No. **245**

Primary Registration District No. **5837**

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

1. PLACE OF DEATH:

(a) County **Newton**
(b) City or town **Neesho, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Station Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Hosp. 1 day**
(Specify whether years, months or days)
In this community **(July) 20 days**

3. (a) PRINT FULL NAME **Piffick, Frank J.**

3. (b) If veteran, name war **X**
3. (c) Social Security No. **Unknown**

4. Sex **Male**
5. Color or race **White**
6. (a) Single, ~~widowed~~, ~~married~~, ~~divorced~~ **Single**

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

7. Birth date of deceased **April 24, 1909**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	34	2	29	_____ hr. _____ min.

9. Birthplace **South Fork Pa.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Soldier**

11. Industry or business **U.S. Army**

MOTHER FATHER { 12. Name **John M. Piffick**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Service Record**

(b) Address **Camp Crowder, Missouri**

17. (a) (Burial, cremation, or removal) **Removal**
(b) Date thereof **July 23, 1943**
(Month) (Day) (Year)

(c) Place: burial or cremation **South Fork, Penn.**

18. (a) Signature of funeral director **Knell Mortuary**
(b) Address **Carthage, Missouri**

19. (a) **7-23-1943** (b) **Cecily Thompson**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED

(a) State **Pa.**
(b) City or town **South Fork**
(If outside city or town limits, write "RURAL")
(c) Street No. **801 Portage St.**
(If rural, give location)
(d) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **23**
year **1943** hour **11** minute **45 AM.**

21. I hereby certify that I attended the deceased from **July 22, 1943**, 19 **July 23, 1943**, 19 **43**
that I last saw him **in** alive on **July 23, 1943**, 19 _____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Sunstroke**

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy **Same as above**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Accident**

(b) Date of occurrence **July 22, 1943**

(c) Where did injury occur? **Camp Crowder, Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public place (In the field)

While at work? **Yes** (Specify type of place)
(c) Means of injury **Sunstroke**

23. Signature **Norman B. Murphy** M.D. or other **MC**
Address **Camp Crowder, Mo.** Date signed **7/23/43**

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

RECEIVED 8-6-43
District Health Officer to.....
District File Number 843-150.....
Date Filed 8-7-43.....

SEP 29 1944

SEP 27 1944

SEP 28 1944

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 *Emmal Stueley*
Licensed Embalmer No. *391*
P. O. Address *Carthage*

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. 245 Primary Registration District No. 5837 Registrar's No. 70

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

1. PLACE OF DEATH:

(a) County Newton
 (b) City or town CAMP CROWDER WBEYTON Twp.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution CAMP CROWDER Station Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ (Specify whether _____)
 years, months or days

3. (a) PRINT FULL NAME Frank J. Tiffuck

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 S

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

7. Birth date of deceased April 24
 (Month) (Day) (Year)

8. AGE: Years 34 Months _____ Days _____ 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)

(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 July Day 23 Year 1943 Hour _____ Minute _____ M.

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

Duration

Due to _____

Due to _____

Other conditions _____ (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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

S-25612