

Registration District No. **28**

Primary Registration District No. **2000**

Registrar's No. **795**

1. PLACE OF DEATH:

(a) County **GREENE**  
(b) City or town **Springfield**  
(c) Name of hospital or institution **1030 CHERRY**  
(d) Length of stay: In hospital or institution **1**  
In this community **1** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **GREENE**  
(c) City or town **SPRINGFIELD**  
(d) Street No. **915 N. PROSPECT**  
(e) Citizen of foreign country? **NO**

3. (a) PRINT FULL NAME **JOHN W. COMBS.**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **500-12-0549**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOWED**

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

7. Birth date of deceased **Feb 27 1871**

8. AGE: Years **72** Months **7** Days **0** If less than one day **hr. min.**

9. Birthplace **Merced Co. Mo**

10. Usual occupation **Travelling Salesman**

11. Industry or business **Salesman**

12. Name **George H. Combs**

13. Birthplace **unk. unknown**

14. Maiden name **Laura Lowry**

15. Birthplace **unk. unknown**

16. (a) Informant **Mrs. Irene Dickey**

(b) Address **Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **Sep 29-1943**

(c) Place: burial or cremation **Green Lawn Cem**

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

(b) Address **Springfield, Mo.**

19. (a) **9-28-43** (b) **B. M. Handley**

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **27<sup>th</sup>** year **1943** hour **12:00** minute **NOON** M.

21. I hereby certify that I attended the deceased from **Sept 17 1943** to **Sept 27 1943** that I last saw him alive on **Sept 26 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Apoplexy** Duration **21 days**

Due to **Hemiplegia** Duration **21 days**

Other conditions **Hemiplegia** (Include pregnancy within 8 months of death) **21 days**

Major findings: Of operations **1234**

Of autopsy **1234**

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

23. Signature **J.B. Prutton** (M.D. or other) **M.D.** Address **Springfield Mo** Date signed **9-27-43**

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

9  
2  
6

029  
2  
6

984

4

**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 A. Brown*

Licensed Embalmer No. *1763*

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.**

X