

S. No. 2  
M-5-42  
5-17-30  
1

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31651

State File No. ....

Registrar's No. .... 784

FILED OCT 7 1943  
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: 905 S. Fremont  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NOBB  
(Specify whether)

In this community 14 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 039

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

(d) Street No. 905 S. Fremont  
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)  
If yes, name country U

3. (a) PRINT FULL NAME William Blaine Killingsworth

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Single

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

7. Birth date of deceased July 26, 1929  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>14</u>	<u>1</u>	<u>25</u>	..... hr. .... min.

9. Birthplace Springfield, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business In School

12. Name W. Blaine Killingsworth

13. Birthplace Walnut Grove, Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Ruby Powell

15. Birthplace Buffalo, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. W. Blaine Killingsworth  
Springfield, Missouri

(b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof 9/23/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home  
Springfield, Missouri

(b) Address Springfield, Missouri

19. (a) 9-23-43 (b) Dr. W. S. Handley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 21  
year 1943 hour 9:45 minute A. M.

21. I hereby certify that I attended the deceased from 7-11  
1943 to 9-21-1943  
that I last saw him alive on 9/21 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Teratoma with metastasis  
origin in R. testicle

Due to .....

Due to .....

Other conditions 5621  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations .....

Of autopsy .....

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 C. E. Feller (M. D. or other)  
Address Springfield, Mo. Date signed 9/24/43

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(Licensed Embalmer's Statement on Reverse Side)

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

OCT 18 1968

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**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.....  
Licensed Embalmer No.....  
P. O. Address.....  
*[Handwritten signature and illegible text]*

**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.**