

FILED JAN 11 1944
128

Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH:
GREENE
(a) County.....
(b) City or town **SPRINGFIELD MO.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **CITY 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)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... **MO.** (b) County **GREENE 37**
(c) City or town **SPRINGFIELD**
(If outside city or town limits, write "RURAL")
(d) Street No. **506 W Olive**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT **MELVEN LENARD CAGLE**
FULL NAME

3. (b) If veteran, **none** name war..... 3. (c) Social Security No. **495-01-0972**

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

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

7. Birth date of deceased **Wid.** **Wid.** **1875**
(Month) (Day) (Year)

8. AGE: Years **68** Months **24** Days **24** If less than one day hr. min.

9. Birthplace **Wid.** **ILL.**
(City, town or county) (State or foreign country)

10. Usual occupation **Wid.**

11. Industry or business.....

MOTHER FATHER

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Hospital records**

(b) Address **SPRINGFIELD MO.**

17. (a) **Burial** (b) Date thereof **Dec 21-1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Park**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **17**
year **1943** hour **8:00** minute **4** M.

21. I hereby certify that I attended the deceased from **12-4**, 1943 to **12-17**, 1943
that I last saw him alive on **12-16**, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary occlusion**

Due to **myocarditis**

Due to.....

Other conditions **neplretis**
(include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

Duration **Sudden**
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)
(b) Means of injury.....

23. Signature **W. Roland Langston** (M. D. or other) **M.D.**
Address **Springfield Mo** Date signed **2/17/43**

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

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.....

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.

Max Rhodes
4071
Springfield
X

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jam
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

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: _____
(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

3. (a) PRINT FULL NAME

Melven L. Cagle

3. (b) If veteran, name war _____ 3. (c) Social Security No. 45-01-0972

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced unk.

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 68 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 _____

MOTHER FATHER

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 Dec year 1943 hour _____ minute _____ M.

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

Due to _____

Due to nephritis chronic

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

Major findings: Of operations _____ Of autopsy _____

Duration _____
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? _____

23. Signature W Robert Foy (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

S-42238