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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 11 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42246

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1026

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: Burge Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days 9 hours (Specify whether
In this community 11 days 9 hours years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler 12 0

(c) City or town Poplar Bluff "Rural"
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Cecil Lee Cravens

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased 12 (Month) 6 (Day) 43 (Year)

8. AGE: Years 0 Months 0 Days 11 If less than one day 9 hr. 10 min.

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

10. Usual occupation Infant

11. Industry or business Infant

FATHER
12. Name Cam L. Cravens
13. Birthplace Essex (City, town, or county) Mo. O (State or foreign country)

MOTHER
14. Maiden name Elizabeth, Martin
15. Birthplace Ark (City, town, or county) Mo. O (State or foreign country)

16. (a) Informant Cam L Craven (Father)
(b) Address 1360 N. Jefferson, Spgfld Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-43 (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director J W Klingner & Co.
(b) Address Springfield Mo.

19. (a) 12-18-43 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 17 year 1943 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from 12-6-, 1943, to 12-17, 1943; that I last saw him alive on 12-17-43, 19..; and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure

Due to Prematurity

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None!

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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? (Specify type of place)

While at work? (e) Means of injury O

23. Signature Edgar L. Engel Md. (M. D. or other)

Address O'Reilly Gen Hosp Springfield Mo. Date signed 12-17-43

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(Licensed Embalmer's Statement on Reverse Side)

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. 4071

P. O. Address Springfield

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.