

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

Registration District No. **FILED JAN 28 1944**

Primary Registration District No. **5465**

Registrar's No. **15**

1. PLACE OF DEATH:

(a) County **GREENE**
Rural Springfield, Campbell Twp.

(b) City or town **Springfield, Campbell Twp.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **Greene County Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **16 days**
(Specify whether years, months or days)

In this community **2 Years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene 39**

(c) City or town **Strafford, Mo. 0**
(If outside city or town limits, write "RURAL")

(d) Street No. **Route #2**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **1**

3. (a) PRINT FULL NAME **Cayce Converse Broom**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **Unk.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **6th.**
year **1944** hour **8:00** minute **A.** M.

4. Sex **Male**

5. Color or race **White**

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

6. (b) Name of husband or wife **Leona May Broom**

6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **Jan. 7th. 1888**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **1943** to **Jan 6**, 19**44**
that I last saw him alive on **Jan 5**, 19**44**
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<input checked="" type="checkbox"/> 55	11	29	hr. min.

Immediate cause of death **Myocarditis, Chronic, Rheumatic**

Duration

9. Birthplace **Unk. Texas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **93C**

Of autopsy

11. Industry or business

12. Name **Sumpter Broom**

13. Birthplace **Unknown Unk 9**
(City, town, or county) (State or foreign country)

14. Maiden name **Nannie Reid**

15. Birthplace **Unknown Unk 9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Leona May Broom**

(b) Address **Strafford, Mo. Rt. 2.**

17. (a) **Burial** (b) Date thereof **1-8-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Dunn Funeral Home**

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

19. (a) **1-8-44** (b) **B. W. Standley**
(Date received local registrar) (Registrar's signature)

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 **3**

23. Signature **James C. Amos** (M. D. or other) **M.D.**
Address **Springfield, Mo.** Date signed **1-7-44**

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... *Clara J. McAdams*
Licensed Embalmer No. *2891*

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.