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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED FEB 10 1944

Registration District No. 128

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

Dr. Feller

State File No. 2849

Registrar's No. 76

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 Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Days  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME George B. Day

3. (b) If veteran, name war No

3. (c) Social Security No. No

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 Dec years

7. Birth date of deceased June 22, 1862  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
✓ 81	6	27		hr. min

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

10. Usual occupation Veterinary

11. Industry or business \_\_\_\_\_

12. Name George Day

13. Birthplace Unk. England  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Unkn own  
(City, town, or county) (State or foreign country)

16. (a) Informant C.M. Day

(b) Address Des Moines, Iowa

17. (a) Burial (b) Date thereof Jan. 21, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marionville, Mo.

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 1-21-44 (b) Dr. W. Handley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 19  
year 1944 hour 1 minute 25 p. M.

21. I hereby certify that I attended the deceased from 1-11- 1944 to 1-12- 1944  
that I last saw him alive on 1-12- 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myo Cardia with decompensation

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions P3d  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 1/21/44

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

MOTHER FATHER

39

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0

Duration

8 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 L. Paulus Gorman

Licensed Embalmer No. 3177

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.**

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