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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 28 1944

Registration District No. 728

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5466

Dr. Calloway

State File No. 7142

Registrar's No. 156

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1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Rural S. Campbell Township (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Route # 8 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: 3 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Greene
(c) City or town: Rural S. Campbell Township (If outside city or town limits, write "RURAL")
(d) Street No.: Route # 8 (If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No) If yes, name country: no

3. (a) PRINT FULL NAME: John Baxter
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: 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: March (Month) 12 (Day) 1866 (Year)
8. AGE: Years: 77 Months: 11 Days: 2 If less than one day ____ hr. ____ min.
9. Birthplace: Glascow (City, town, or county) Scotland (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business: ____
12. Name of father: David Baxter
13. Birthplace of father: Unk. (City, town, or country) Scotland (State or foreign country)
14. Maiden name of mother: Unk. Cuthbertson
15. Birthplace of mother: Unk. (City, town, or county) Scotland (State or foreign country)
16. (a) Informant: W. C. Baxter
(b) Address: Springfield, Mo. Route # 8
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 15, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation: ~~Greenlawn~~ HAZELWOOD
18. (a) Signature of funeral director: H. H. Lohmeyer
(b) Address: Springfield, Mo.
19. (a) 2-15-44 (Date received local registrar) (b) S. W. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Feb. day: 14 year: 1944 hour: 6:00 minute: a. M.
21. I hereby certify that I attended the deceased from Feb 8, 1944, to Feb 14, 1944 that I last saw him alive on Feb 10, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Apoplexy (Cerebral hemiplegia) — Duration: 3d.
Due to: ____
Due to: ____
Other conditions: Hypertension
(Include pregnancy within 3 months of death)
Major findings:
Of operations: ____
Of autopsy: ____

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: 0
23. Signature: Guy D. Calloway (M. D. or other) MD
Address: Springfield Mo. Date signed: 2/15/44

984

(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 Walter E Hamilton

Licensed Embalmer No. 3808

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.