

FILED APR 10 1944

Registration District No. 128

Primary Registration District No. 2000

Registrar's No.

283

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:
2111 BENTON 1
 (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 **CHARLES A. HOLSINGER**3. (b) If veteran, **NONE** name war. 3. (c) Social Security No. **NONE**4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced. **MARRIED**6. (b) Name of husband or wife **ALIDA MAY HOLSINGER** 6. (c) Age of husband or wife if alive **68** years7. Birth date of deceased. **Aug. 24, 1872**
(Month) (Day) (Year)8. AGE: Years **71** Months **7** Days **3** If less than one day
hr. min.9. Birthplace **MURRYSVILLE PA. 1**
(City, town, or county) (State or foreign country)10. Usual occupation **Farming**11. Industry or business **Farming**12. Name **John Holsinger**13. Birthplace **West Germany Pa. 4**
(City, town, or county) (State or foreign country)14. Maiden name **Fannie Farming**15. Birthplace **West. Pa. 1**
(City, town, or county) (State or foreign country)16. (a) Informant **Alida May Holsinger**(b) Address **2111 Benton, Spfld. Mo.**17. (a) **Burial** (b) Date thereof **Mar 29-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Maple Park**18. (a) Signature of general director **J.W. Klingner & Co.**(b) Address **Springfield, Mo.**19. (a) **3-28-44** by **D. W. Stauder**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Greene**
 (c) City or town **Springfield**
 (If outside city or town limits, write "RURAL")
Benton
 (d) Street No. **2111**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country **✓**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **27**
year **1944** hour **8** minute **30 P.** M.21. I hereby certify that I attended the deceased from **1-27-** 19**44** to **3-27-** 19**44**
that I last saw him alive on **3-20-** 19**44**
and that death occurred on the date and hour stated above.Immediate cause of death **Carcinoma of face** Duration**& head.**

Due to.....

Due to.....

Other conditions **53**
(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.....

23. Signature **Thurs. J. Knapp** M. D. **3/28/44**Address **W. 1st St. Council** Date signed **3/28/44**

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 J. B. Klugner
Licensed Embalmer No. 3358

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Y