

FILED MAY 9 1944

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 353

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:
412 E. HARRISON
(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

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. 412 E. HARRISON
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert Danforth

3. (b) If veteran, name war World War I 3. (c) Social Security No. Unk.

4. Sex Male 5. Color Col. 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 February Unk. 1892
(Month) (Day) (Year)

8. AGE: Years 52 Months 2 Days unk If less than one day _____ hr. _____ min.

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

10. Usual occupation Hod Carrier

11. Industry or business _____

12. Name Pete Danforth

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

14. Maiden name Ida Cannefax

15. Birthplace Unk. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Leslie Gibson

(b) Address 946 S. Roberson, Spfld. Mo.

17. (a) Burial (b) Date thereof 4-26-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation National Cem

18. (a) Signature of funeral director W.P. Campbell
(b) Address 867 Washington, Spfld. Mo.
19. (a) 4-25-44 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 21 at
year 1944 hour 9:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from 4-14-
1944, to 4-14- 1944
that I last saw him alive on 4-14- 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis
for advanced

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy 13 fl

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 R.P. Jenkins (M. D. or other) MD.
Address 305 1/2 College St. Date signed 4-24-44

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

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.

MAY 10 1944

Signed W. P. Campbell
Licensed Embalmer No. 1747
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.

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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
2531
Registrar's No. _____

Registration District No. 128 Primary Registration District No. 2000

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert Danforth
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race B
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sub. - 1892
(Month) (Day) (Year)

8. AGE: Years 52 Months 2 Days _____ If less than one day _____ min.
9. Birthplace Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

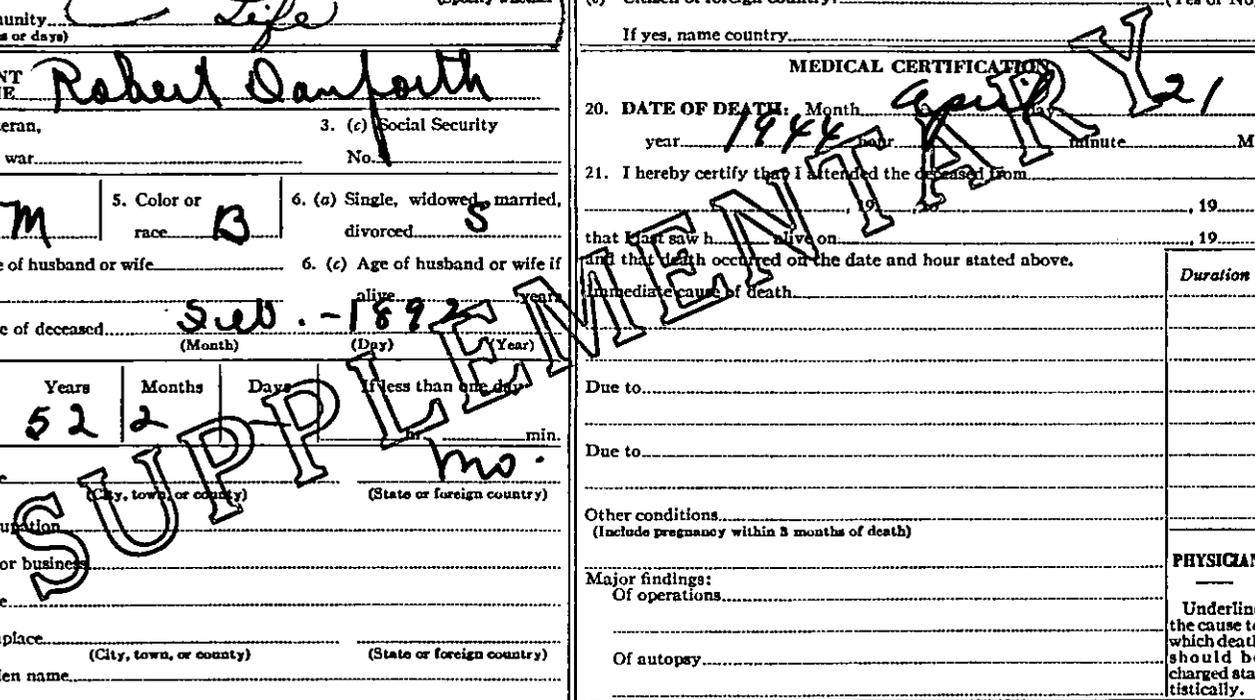
16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) R. W. Haines
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April Year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions (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 _____ (M. D. or other) _____
Address _____ Date signed _____



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

PHYSICIAN
Underline the cause to which death should be charged statistically.

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