

FILED MAY 24 1944

Registered in District No. 128

Primary Registration District No. 2000

383

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: SPRINGFIELD BAPTIST HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 DAYS (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County GREENE. 39
(c) City or town Rural in Campbell Twp.
(If outside city or town limits, write "RURAL")
(d) Street No. R. F. D. #1
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ROBERT THOMAS McMAHON

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

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 April 28 - 1944
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 2
year 1944 hour 2 minute 5 A.M.

21. I hereby certify that I attended the deceased from 4/28 1944 to 5-2- 1944
that I last saw him alive on 5-21 1944
and that death occurred on the date and hour stated above,

Immediate cause of death Delusory injury possibly lacerative tentorium
Duration 3 1/2 days

8. AGE: Years 0 Months 0 Days 4 If less than one day hr. min.

9. Birthplace Springfield Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

12. Name John Lawrence Mc Mahon

13. Birthplace Little Rock Ark. 1
(City, town, or county) (State or foreign country)

14. Maiden name Gladyce Mildred Gustafson

15. Birthplace Springfield Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lawrence Mc Mahon

(b) Address R# 1 Springfield, Mo.

17. (a) Burial (b) Date thereof May 3, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenham Cem

18. (a) Signature of funeral director J. W. Lingner & Co.

(b) Address Springfield, Mo.

19. (a) 5-3-44 (b) Dr. W. H. Handley
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations 1600
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 C. S. Zeller D. (M. D. or other) _____
Address Springfield Mo. Date signed 5/2/44

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

2
41
39
26390

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 *Ogle Stone, Jr.*

Licensed Embalmer No. *4176*

P. O. Address *Springfield*

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.

X