No. 2
-5-42
17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Smith 21576

State File No. .....

FILED JUN 22 1944

Registration District No. 1228

Primary Registration District No. 2002

Registrar's No. 504

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 Bapst. Hosp. 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1½ Months (Specify whether

In this community 18 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 29

(c) City or town Springfield 2 (If outside city or town limits, write "RURAL")

(d) Street No. 846 S. Pickwick 6 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Harry Palos

3. (b) If veteran, name war No

3. (c) Social Security No. 335-09-3247

4. Sex Male 0

5. Color or race White 1

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frances Pales

6. (c) Age of husband or wife if alive Unk. years

7. Birth date of deceased July (Month) 2, (Day) 1885 (Year)

8. AGE: Years 58 Months 11 Days 12 If less than one day ..... hr. ..... min.

9. Birthplace Belleville Ontario Canada 2 (City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Continental Can Co.

FATHER
12. Name Federick Palos
13. Birthplace Unk. England 4 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ellen Warham
15. Birthplace Unk. Canada 2 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frances Palos

(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16, 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood

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

(b) Address Springfield, Mo.

19. (a) 6-16-44 (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14 year 1944 hour 6 minute 35a. M.

21. I hereby certify that I attended the deceased from Apr 26 1944 to June 14 1944 that I last saw him alive on June 14 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cirrhosis of Liver

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

124 P1

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature Hallys Smith (M. D. or other) MD

Address Springfield Mo Date signed 6-15-44

(Licensed Embalmer's Statement on Reverse Side)

JUL 29 1948

NOV 29 1948

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. Doshie Foreman

Licensed Embalmer No. 3177

P. O. Address Springfield Me

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.

No. 2B
1—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 504

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 ..... years, months or days)

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 .....

3. (a) PRINT FULL NAME Harry Palas

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased July (Month) 2 (Day) 1882 (Year)

8. AGE: Years 58 Months 11 Days 12 If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) Dr W E Hardy (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June 24
year 1944 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....;
that I last saw h..... alive on ..... 19.....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions ..... (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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

NOV 23 1944

21576