V. S. No. 2
50M—9-4-41
Rev. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24705

FILED JUL 25 1944

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 570

39
2
6

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

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: 1357 S. National
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 2 Mo.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield 4
(If outside city or town limits, write "RURAL") 6

(d) Street No. 1357 S. National
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Robert Ryan Mc Clernon

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

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 (Month) 25 (Day) 1944 (Year)

8. AGE: Years 0 Months 2 Days 25 If less than one day hr. min.

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

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Frances H. Mc Clernon
13. Birthplace Springfield (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name Mary Ryan
15. Birthplace Chicago (City, town, or county) Ill 1 (State or foreign country)

16. (a) Informant Frances H. Mc Clernon
(b) Address Springfield Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11 1944 (Month) (Day) (Year)
(c) Place: burial or cremation St. Marys Cem

18. (a) Signature of funeral director H. H. Lohmeyer
(b) Address Springfield Mo.

19. (a) 7-12-44 (Date received local registrar) (b) Dr W. J. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10
year 1944 hour 3:00 minute P M.

21. I hereby certify that I attended the deceased from No Physician in attendance, 19
that I last saw h alive on 19
and that death occurred on the date and hour stated above.

Immediate cause of death Status Thymicolymphaticus

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

64

Major findings:
Of operations

Of autopsy Thymic + lymphoid hyperplasia. Adrenal hypoplasia

Duration

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 Murray C. Stone Coroner (M. D. or other)
Address Springfield, Mo Date signed 7-12-44

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 H J McCann

Licensed Embalmer No. 2727

P. O. Address Springfield Ma

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.