V. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 10 1945

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41168

Primary Registration District No. 2000

Registrar's No. 938

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: 2634 N. Weller
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
In this community 14 from SW Mo. (Specify whether 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. 2634 N. Weller
(If rural, give location)

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

3. (a) PRINT FULL NAME Henry Clay Lester

3. (b) If veteran, name war No

3. (c) Social Security No. Unk.

4. Sex Male

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Sept. (Month) 13 (Day) 1881 (Year)

8. AGE: Years 63 Months 3 Days 1 If less than one day hr. min.

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

10. Usual occupation State Highway Dept.

11. Industry or business Maintenance Patrolman

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

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

16. (a) Informant Mrs. Mildred Andrews
(b) Address 1414 E. Kerry, Spfd., Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-44 (Month) (Day) (Year)
(c) Place: burial or cremation East Lawn Cemetery

18. (a) Signature of funeral director Fred C. Thieme
(b) Address 1100 Boonville Ave. Spfd. Mo.

19. (a) 12-19-44 (Date received local registrar) (b) D. M. Hancock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 18 year 1944 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from ~~12~~ 7-3, 19xx to 12-18, 19xx that I last saw him alive on 11-10, 19xx and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary occlusion	5 mo
Due to	
Due to A H D	
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
(f) Signature C. E. Feller (M. D. or other)
Address Springfield, Mo. Date signed 12-19-44

(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 Fred C. Thieme

Licensed Embalmer No. 2899

P. O. Address Springfield, Mo

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.

X