

S. No. 2
DM-2-43
v. 5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41190

FILED JAN 10 1948

Registration District No. 129

Primary Registration District No. 2000

Registrar's No. 934

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

1. PLACE OF DEATH:

(a) County Greene, mo

(b) City or town Springfield mo
(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 12 hrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield mo Rural
(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 Philip Thomas Preston

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 47 years

7. Birth date of deceased July 22, 1907
(Month) (Day) (Year)

8. AGE: Years 17 Months 4 Days 24 hr. _____ min. _____

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

10. Usual occupation School Boy

11. Industry or business _____

MOTHER FATHER

12. Name P. O. Preston

13. Birthplace Greene Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Alma Louise Preston

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

16. (a) Informant P. O. Preston

(b) Address Springfield mo

17. (a) Burial (b) Date thereof Dec 19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield mo

18. (a) Signature of funeral director Harrison Allen

(b) Address Springfield mo

19. (a) 12-18-44 (b) O. W. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17 year 1944 hour 10:00 minute am

21. I hereby certify that I attended the deceased from Dec 16-44 to Dec 17, 1944
that I last saw him alive on Dec 17, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: pneumococcus meningitis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) g. l. b.

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature H. O. Preston (M. D. or other) _____

Address Springfield mo Date signed 12-18-44

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.....

Wm A. Allison

Registered Apprentice No. *366*

working under my personal supervision.

Signed *R. L. Hamschild*

Licensed Embalmer No. *3934*

P. O. Address *Lakewood, Ill*

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.

Y