

No. 2
5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2187

State File No.

FILED JAN 25 1945

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 3271

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 832 S. NETTLETON
(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 MO. (b) County GREENE 3?
(c) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL")
(d) Street No. 832 S. NETTLETON
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT NAME PRESS N. COLWELL
FULL NAME
(b) If veteran, name war NO
(c) Social Security No. NO

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month JAN. day 11
year 1945 hour 7 minute 25 P.M.
21. I hereby certify that I attended the deceased from 1937
19 _____ to 1-11 1945
that I last saw him alive on 1-11-45 19 _____
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
(b) Name of husband or wife SUSAN FLORA COLWELL
(c) Age of husband or wife if alive 83 years
7. Birth date of deceased April 25 1857
(Month) (Day) (Year)

Immediate cause of death Uremic Poisoning Duration 1 year
Due to Senile
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years 87 Months 8 Days 16
If less than one day _____ hr. _____ min.

9. Birthplace UNK. UNK.
(City, town, or county) (State or foreign country)
10. Usual occupation Retired Pharmacist

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name Thomas Cabwell
13. Birthplace unk. missouri
(City, town, or county) (State or foreign country)
14. Maiden name James E. Strader
15. Birthplace unk. missouri
(City, town, or county) (State or foreign country)
16. (a) Informant Susan Flora Cabwell
(b) Address 832 S. Nettleton, Springfield, Mo.
17. (a) Burial (b) Date thereof 1-13-1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Maple Park only
18. (a) Signature of funeral director W. H. Wagner & Co.
(b) Address Springfield, Mo.
19. (a) 1-12-45 (b) D. N. J. Handley
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Place 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 Albert H. Shanks (M. D. or other) _____
Address 781 College Park Date signed 1/12-45

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

784

Spfld., Mo.

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

Ray A. Leavin

Licensed Embalmer No. *1763*

P. O. Address *Sperryville, MD*

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.

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:
(a) County Shelby
(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

3. (a) PRINT FULL NAME Press N. Colwell
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 April 25 (Month) (Day) (Year)

8. AGE: Years 87 Months 8 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

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) _____ (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis
with some symptoms

Duration 5 years

Due to _____

Due to 131 lb

Other conditions _____ (Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Albert Sparkes (M. D. or other) _____

Address 781 College St Date signed _____
Springfield MO

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

SUPPLEMENTARY

S-2104