S. No. 2
1—5-42
5-17-39
P I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 30 1945

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

State File No. 9637

Registrar's No. 200

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: 1720 N. FLORENCE
(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 39

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

(d) Street No. 1720 N. Florence
(If rural, give location)

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

If yes, name country ✓

3. (a) PRINT FULL NAME WILLIAM JARRETT BRANSON.

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 WIDOWER 2

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

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

7. Birth date of deceased April (Month) 24 (Day) 1863 (Year)

8. AGE: Years 81 Months 10 Days 16 If less than one day ..... hr. ..... min.

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

10. Usual occupation Retired Frisco Employee

11. Industry or business R.R.

FATHER
12. Name William J. Branson
13. Birthplace Aud. (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Polly Anna Hatton
15. Birthplace Aud. (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Mrs. Dave Kuhns
(b) Address 1720 N. Florence, Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 14-1945 (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cem.

18. (a) Signature of funeral director J. W. Klingner & Co.

(b) Address Springfield, Mo.

19. (a) 3-14-45 (Date received local registrar) (b) Sr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10 year 1945 hour 10 minute 25 AM.

21. I hereby certify that I attended the deceased from Jan 15, 1945, to Mar 10, 1945 that I last saw him alive on Mar 8, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hemorrhage of Stomach	2 days
Due to unknown	
Due to	
Other conditions arterio sclerosis (Include pregnancy within 3 months of death)	unknown

Major findings:
Of operations ..... ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 W. T. Walsh (M. D. or other)

Address Springfield, Mo. Date signed 3/10/45

(Licensed Embalmer's Statement on Reverse Side)

APR 17 1945

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.....J B Klingner

Licensed Embalmer No.....3358

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.

S. No. 2B
M—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. April

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 200

SUPPLEMENTARY

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)

3. (a) PRINT FULL NAME Wm J. Branson

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 W

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 24 (Day) 1862 (Year)

8. AGE: Years 81 Months 10 Days 6 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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) (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 March day 10
year 1945 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.

Immediate cause of death | Duration

Due to probable carcinoma of stomach.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 4/6/

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 W. T. Walsh (M. D. or other)
Address Springfield Mo Date signed 4/26/48

S. No. 2B
M—5-43
Form 1 X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.....

1. PLACE OF DEATH:

(a) County.....

(b) City or town.....
(If outside city

(c) Name of hospital or instit

.....
(If not in hospital

(d) Length of stay: In

In this community.....
years, months or days)

3. (a) PRINT
FULL NAME.....

3. (b) If veteran,

name w

4. Sex.....

6. (b) N

.....

7. B

8.

9637

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) ..... (b) .....
(Date received local registrar) (Registrar's signature)

(c) W

(d) Did injury occur in or about ho

.....
(Specify type of place)

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

23. Signature..... (M. D. or other).....

Address..... Date signed.....

MAR... E. PREVENTING BLACK INK—WHERE A DEPARTMENT RECORD