

S. No. 2
M-5-42
v. 5-17-39
X32873

Dr. Fitch 9702

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 30 1945
128

Registration District No.

Primary Registration District No. 2000

Registrar's No. 212

1. PLACE OF DEATH:

(a) County **GREENS**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. John's Hosp.**
(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 **Missouri** (b) County **Greene**
(c) City or town **Springfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **844 N. Campbell**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

James W. Rozar

3. (b) If veteran, name war **W.W. # 1**

3. (c) Social Security No. **500-05-6690**

4. Sex **Male** (1) 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Velma Rozar**
6. (c) Age of husband or wife if alive **70** years
7. Birth date of deceased **December 13, 1894**
(Month) (Day) (Year)

8. AGE: Years **50** Months **3** Days **0**
If less than one day hr. min.

9. Birthplace **Centerton Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **FILLING STATION ATTENDANT**

11. Industry or business

12. Name **Unknown**
13. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Velma Rozar**
(b) Address **Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **3/17/45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **National Cemetery**

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

19. (a) **3-15-45** (b) **H. Handley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **13**
year **1945** hour **5** minute **30 a.m.**

21. I hereby certify that I attended the deceased from **Mar 11** to **Mar 13** 19**45**
that I last saw him alive on **Mar 11** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial infarction**
Duration **24 hrs.**

Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....
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. Handley** (M. D. or other)
Address **Springfield, Mo.** Date signed **3-24-45**

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

SEP 20 1949

APR 5 1945

APR 2 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 *Walter E Hamilton*

Licensed Embalmer No. *3808*

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