S. No. 2
M—5-42
v. 5-17-39
1 X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 3 1945

Registration District No. 130

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13382

Primary Registration District No. 5463 A

Registrar's No. 71

1. PLACE OF DEATH:

(a) County: GREENE

(b) City or town: Fair Grove Route 2 (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Fair Grove Route 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... In this community 77 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene

(c) City or town: Fair Grove Route 2 (If outside city or town limits, write "RURAL")

(d) Street No.: Fair Grove Route 2 (If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME: William Thomas Breshears

3. (b) If veteran, name war: No.

3. (c) Social Security No.: No.

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Lucinda

6. (c) Age of husband or wife if alive: 67 years

7. Birth date of deceased: November 24, 1867 (Month) (Day) (Year)

8. AGE: Years 77 | Months 4 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace: Dallas Co. Missouri (City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER
12. Name: James K. Breshears
13. Birthplace: Lawerence Co. Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Mary N. McDonald
15. Birthplace: Unkown (City, town, or county) (State or foreign country)

16. (a) Informant: William R. Breshears
(b) Address: Springfield, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 29-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Belleview

18. (a) Signature of funeral director: J. W. Klingner & Co.
(b) Address: Springfield, Missouri

19. (a) 4/26/45 (Date received local registrar) (b) Garland Harrison (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23 year 1945 hour ..... minute 4:15 P.M.

21. I hereby certify that I attended the deceased from Apr. 23 1945 to Apr. 23 1945 that I last saw him alive on Apr. 22 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral hemorrhage	12 hrs
Due to Arteria-sclerosis	yrs
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 830
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: Arthur D. Krafft M.D. or other
Address: 4-5 N. E. Court Date signed 4-24-45

1344

(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.....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.