

FILED APR 25 1945

Primary Registration District No. **2000**

Registrar's No. **280**

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: **Burge Hospital**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 1/2 hrs.**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lexa**

(c) City or town **Ellis Prairie**  
(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 **Robert David Holland**

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 **Infant**

6. (b) Name of husband or wife **NONE**

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

7. Birth date of deceased **3 - 28 - 1945**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>0</b>	<b>8</b>	<b>5</b>	hr. _____ min. _____

9. Birthplace **Ellis Prairie Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business \_\_\_\_\_

12. Name **William E. Holland**

13. Birthplace **Licking Mo.**  
(City, town, or county) (State or foreign country)

14. Maiden name **William Irene Holland**

15. Birthplace **Ellis Prairie Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **William E. Holland**

(b) Address **Ellis Prairie Mo.**

17. (a) **Burial** (b) Date thereof **4-3-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ellis Prairie Mo.**

18. (a) Signature of funeral director **John R. Schreyer**

(b) Address **Springfield Mo.**

19. (a) **4-4-45** (b) **DR H. H. Haudley**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **3** year **45** hour **8** minute **35 P.M.**

21. I hereby certify that I attended the deceased from **4-2-1945** to **4-3-1945**

that I last saw him alive on **4-3-45** and that death occurred on the date and hour stated above.

Immediate cause of death **Seranus Mesenterium**

Duration **2d**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **12**

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) \_\_\_\_\_

(e) Means of injury \_\_\_\_\_

23. Signature **Clara Busch** (M. D. or other)

Address **Springfield Mo.** Date signed **4-3-45**

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

966

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**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 Harlow Knabl

Licensed Embalmer No. 4065

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.**