No. 2
-9-4-41
5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16943

FILED JUN 11 1945

Registration District No. 318 128

Primary Registration District No. 5461

Registrar's No.

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: James River, Greene County, Missouri (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: None (Specify whether years, months or days)

In this community: 14 years

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.: 517 N. Farmer (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: Gerald Loyd Quackenbush

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: Single

6. (b) Name of husband or wife:

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

7. Birth date of deceased: January (Month) 2, (Day) 1930 (Year)

8. AGE: Years 15 Months 4 Days 28 If less than one day: hr. min.

9. Birthplace: Ft. William (City, town, or county) Canada (State or foreign country)

10. Usual occupation: Student

11. Industry or business: In School

MOTHER FATHER

12. Name: Arthur D. Quackenbush

13. Birthplace: Toledo, (City, town, or county) Iowa (State or foreign country)

14. Maiden name: Beulah Scogsdill

15. Birthplace: Cabool, (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Arthur D. Quackenbush

(b) Address: Springfield, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: June (Month) 2 (Day) 1945 (Year)

(c) Place: burial or cremation: East Lawn Cemetery

18. (a) Signature of funeral director: Alma Lohmeyer Funeral Home

(b) Address: Springfield, Missouri

19. (a) June 2-45 (Date received local registrar) (b) Mrs. Frank Smith (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 30 year: 1945 hour: 1 5 minute: 30 P.M.

21. I hereby certify that I attended the deceased from: No Physician 19 to attendance 19 that I last saw it alive on 19 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Accidental drowning	
Due to: while bathing	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 1 8 3 1 3	
Of autopsy: 1 8 3 1 8	

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): Accident E 39

(b) Date of occurrence: May 30, 1945

(c) Where did injury occur? Greene (City or town) Mo. (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? James River (Specify type of place)

While at work? No (e) Means of injury: 9

23. Signature: Norman C. Stone, Coroner (M.D. or other)

Address: Springfield, Mo. Date signed: 5-31-45

(Licensed Embalmer's Statement on Reverse Side)

1297

JUL 30 1954

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 Smith

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
-3-45
X43880

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. June

Registration District No. (128) Primary Registration District No. (5461) Registrar's No.

1. PLACE OF DEATH:

(a) County Greene Co. Clay Twp.

(b) City or town Springfield R#9
(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)

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

3. (a) PRINT FULL NAME Gerald L. Quackenbush

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan (Month) 2 (Day) 1920 (Year)

8. AGE: Years 15 Months 4 Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) (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) Mrs. Frank Smith (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month May day 30
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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

16943