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ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 13 1945

State File No. 23977

Registration District No. 128 Primary Registration District No. 2063 Registrar's No. 592

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: 736 WOODLAWN 1
(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. 736 Woodlawn
(If rural, give location)

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

If yes, name country ✓

3. (a) PRINT FULL NAME FRANK W. KIDD

3. (b) If veteran, name war NONE

3. (c) Social Security No. 491-03-6262

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife FAY KIDD

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

7. Birth date of deceased DEC. 9 (Month) 1890 (Day) (Year)

8. AGE: Years 54 Months 7 Days 20 If less than one day ..... hr. ..... min.

9. Birthplace Buffalo (City, town, or county) MO. 0 (State or foreign country)

10. Usual occupation Butcher (meat cutter)

11. Industry or business Butcher Shop

FATHER
12. Name James Kidd
13. Birthplace UNK (City, town, or county) Ohio 1 (State or foreign country)

MOTHER
14. Maiden name Elizabeth Monday
15. Birthplace Dallas Co. (City, town, or county) Mo. 1 (State or foreign country)

16. (a) Informant Fay Kidd

(b) Address SPRINGFIELD MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood Cem.

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

(b) Address SPRINGFIELD MO.

19. (a) 7-30-45 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29 year 1945 hour 7 minute 45 P. M.

21. I hereby certify that I attended the deceased from 7/29 1945, to 7-29 1945 that I last saw him alive on June 1940 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Heart Condition (Valvular) Duration

Due to Chronic Gastritis 1 Hr

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations no

Of autopsy none

8.3

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 A F Freeman (M. D. or other)

Address Springfield Mo Date signed 7/30/45

984

(Licensed Embalmer's Statement on Reverse Side)

FEB 23 1946

SEP 6 1946

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.

X