S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 12 1945

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 27376

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 665

**1. PLACE OF DEATH:**

(a) County: Gree ne

(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1701 S. Fremont
(If not in hospital or institution, write street number or location)

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

In this community .....

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: Greene 39

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

(d) Street No.: 2151 Travis 6
(If rural, give location) 0

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

If yes, name country .....

3. (a) PRINT FULL NAME: John W. Hale

3. (b) If veteran, name war: UNK.

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

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Nancy N. Hale

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

7. Birth date of deceased: October (Month) 21 (Day) 1863 (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| ✓ | 81 | 10 | 1 | hr. ____ min. |

9. Birthplace: UNK. (City, town, or county) UNK. (State or foreign country)

10. Usual occupation: Retired Construction Wrk.

11. Industry or business: ?

FATHER
12. Name: Edmond Hale
13. Birthplace: Ozark Co. Mo. ? (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Nancy Ann Murphy
15. Birthplace: Ozark Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Henry Jones
(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Greenlawn

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

19. (a) 8-25-45 (Date received local registrar) (b) W. Hartley (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month August day 22 year 1945 hour ..... minute 6:10p M.

21. I hereby certify that I attended the deceased from 5-29, 1943 to 8-22, 1945 that I last saw him alive on 8-8, 1945 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Coronary occlusion. | few min. |
| Due to: Arteriosclerotic Heart disease. | 2½ yrs |
| 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 D

23. Signature: ..... (M. D. or other)

Address: Springfield Mo. Date signed 8-27-45

984 (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: Nat Rhodes

Licensed Embalmer No. 4071

P. O. Address: Lapel, 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.**