No. 2
—5-42
5-17-39
I X32873

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

State File No. 27395

FILED SEP 13 1945

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 645

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 (Specify whether

In this community 6 days 2½ hrs. years, months or days)

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. 2203 O. Mill (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Wm. McAnespie

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 Viola McAnespie

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased March (Month) 24 (Day) 1892 (Year)

8. AGE: Years 53 Months 4 Days 22 If less than one day hr. min.

9. Birthplace Springfield (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Meat Cutter

11. Industry or business O'Reilly Gen. Hosp.

FATHER
12. Name James McAnespie
13. Birthplace UNK. (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Mary Wise
15. Birthplace New York (City, town, or county) N.Y. (State or foreign country)

16. (a) Informant Wm. Lee Langley

(b) Address 1711 W. Walnut, SPFD., MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18 1945 (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cemetery

18. (a) Signature of funeral director Alma Lohmeyer

(b) Address Springfield Mo.

19. (a) 8-17-45 (Date received local registrar) (b) S. W. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 16 year 1945 hour 10 minute 35 M.

21. I hereby certify that I attended the deceased from 8-10-45, 1945 to 8-16, 1945 that I last saw him alive on 8-16, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia Hypostatic	4 D.
Due to Internal Injury	6 D
Due to Auto Accident Collision	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 3

(b) Date of occurrence 8-10-45

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place - Corner Webster + Newton (Specify type of place)

While at work? No (e) Means of injury Auto Accident

23. Signature [signature] (M. D. or other)

Address SPFD., MO. Date signed 8-16-45

(Licensed Embalmer's Statement on Reverse Side)

SEP 20 19

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

No. 2B
M—3-45
I 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. Sept

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 645

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:
(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 Wm McAnespie

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Mar (Month) 24 (Day) 1892 (Year)

8. AGE: Years 53 Months 4 Days 22 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26
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.

Immediate cause of death Bronchopneumonia
Hypostatic
Due to Injury - Internal Organs
Due to Auto - Ne - Auto
Collision - Intersection
Other conditions Fool - Rider
(Include pregnancy within 3 months of death)
Collision with Ne auto

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 17 DEC 8 22

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 8 - - '45

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Intersection - In City
(Specify type of place)
While at work? On Waybom (e) Means of injury See above

23. Signature [illegible] (M.D. or other)
Address Date signed 9-21-45

SUPPLEMENTARY

5-27395