

S. No. 2
M-5-43
5-17-39
I X3667

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27401

State File No. _____

FILED SEP 28 2 1945
Registration District No. _____

Primary Registration District No. **2000**

Registrar's No. **672**

1. PLACE OF DEATH:
(a) County **GREENE**
(b) City or town **Springfield**
(c) Name of hospital or institution: **Springfield Baptist Hospital**
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Stone** **104**
(c) City or town **Crane Rural** **0**
(If outside city or town limits, write "RURAL")
(d) Street No. **0**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Matney, Ronald Alan**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **24**
year **1945** hour **5** minute **10 P.** M.

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 **XX** years
7. Birth date of deceased **June 12, 1945**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Aug. 24, 1945**, to **Aug. 24, 1945**, that I last saw him alive on **Aug. 24, 1945**, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
0 **2** **12** hr. min.

Immediate cause of death **Broncho pneumonia** Duration **2d**

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

Due to **Acc. entericis** **4d**

10. Usual occupation **INFANT**

Due to _____
Other conditions (Include pregnancy within 3 months of death) **N**

11. Industry or business _____

Major findings: Of operations _____
Of autopsy **110/2**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name **Eugene Matney**
13. Birthplace **Capetain** **Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Therese Hagler**
15. Birthplace **Crane** **Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Eugene Matney**
(b) Address **Crane, Mo.**

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

18. (a) Signature of funeral director **Geo. H. Manlove**
(b) Address **Crane, Mo.**

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

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **Hubert Bense** (M. D. or other) _____
Address **Springfield, Mo.** Date signed **8-25-45**

984 (Licensed Embalmer's Statement on Reverse Side)

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

9
2
6

11

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: *George H. Moulton*

Licensed Embalmer No. *3827*

P. O. Address: *Cram 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