

FILED OCT 9 1945  
Registration District No. 128

Primary Registration District No. 5465

State File No. \_\_\_\_\_  
Registrar's No. 714

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

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: R.F.D. # 4  
(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 <sup>39</sup>

(c) City or town Springfield - Campbell Twp  
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. # 4  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or NO)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ALVA R. SELBY.

(b) If veteran, name war NONE

(c) Social Security No. UNK.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19  
year 1945 hour 7 minute 35 P.M.

21. I hereby certify that I attended the deceased from 9, 11, 45 19. to 9, 19, 45 19. that I last saw him alive on 9, 17, 45 19. and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife UNK.

6. (c) Age of husband or wife if alive Dec years 15 1874  
(Day) (Year)

7. Birth date of deceased April  
(Month) (Day) (Year)

Immediate cause of death Hemorrhage, cerebral Duration 3 days

8. AGE: Years 71 Months 5 Days 4  
If less than one day hr. min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation Rating farmer (5 yr.)

11. Industry or business Farming

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER } 12. Name Unknown

13. Birthplace UNK. Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace UNK. Unknown  
(City, town, or county) (State or foreign country)

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? (c) Means of injury \_\_\_\_\_

23. Signature Jos Muck (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo. Date signed 9, 20, 45

16. (a) Informant Earl Selby

(b) Address Springfield Mo.

17. (a) Funeral Home (b) Date thereof 9-21-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marionville, Mo.

18. (a) Signature of funeral director W. H. Hargraves  
Springfield, Mo.

(b) Address \_\_\_\_\_

19. (a) 9-21-45 (b) Jos Muck  
(Date received local registrar) (Registrar's signature)

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**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 Egle Stone Jr.  
Licensed Embalmer No. 4176  
P. O. Address Springfield

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

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