

U.S. No. 2  
FORM-5-43  
REV. 5-17-39  
I X36671

DEPARTMENT OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33746

State File No. \_\_\_\_\_

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 840

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:  
St. John's Hospital 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution two days (Specify whether 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. 728 E. Sunshine  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JON CALVIN JANSS

3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Male 0 5. Color or race White  
6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None  
6. (c) Age of husband or wife if alive XX years  
7. Birth date of deceased October 16, 1945  
(Month) (Day) (Year)

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

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

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Herman Janss

13. Birthplace Marshalltown, Iowa  
(City, town, or county) (State or foreign country)

14. Maiden name Maude Eva McCord

15. Birthplace Galena, Kansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Herman Janss

(b) Address 728 E. Sunshine St., Springfield, Mo

17. (a) Burial (b) Date thereof 10/19/1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 10-19-45 (b) Dr. H. H. Handley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 18,  
year 1945 hour 6: minute 00 A. M.  
21. I hereby certify that I attended the deceased from Oct 16  
1945 to Oct 18, 1945  
that I last saw him alive on Oct 18, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Arteriosclerosis

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

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 1570

Duration \_\_\_\_\_  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_

23. Signature J. J. Johnston (M. D. or other) MD

Address Springfield, Mo Date signed \_\_\_\_\_

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

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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.....

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.**