S. No. 2
M—2-43
v. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

33785

State File No.

FILED NOV 6 1945

Registration District No. 122

Primary Registration District No. 5455

Registrar's No. 22

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

39
0
0

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Republic Republic Tw

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

(c) Name of hospital or institution: R. F. D. # 1

(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 31

(c) City or town Republic

(If outside city or town limits, write "RURAL")

(d) Street No. R. F. D. # 1

(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME CLINTON PONDER

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Jane Ponder

6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased Feb. (Month) 1 (Day) 1901 (Year)

8. AGE: Years 45 Months 8 Days 29 If less than one day hr. min.

9. Birthplace Whitewright Texas (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

FATHER
12. Name Ponder
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Murray
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Jane Ponder

(b) Address Republic Mo. R. # 1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Evergreen Cem.

18. (a) Signature of funeral director J. W. Klingner & Co.

(b) Address Springfield Mo.

19. (a) Nov. 1-1945 (Date received local registrar) (b) Florence Britain (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month October 30 year 1945 hour 5 minute 20 P. M.

21. I hereby certify that I attended the deceased from OVER ONE YEAR, 19..., to ..., 19..., that I last saw him alive on 10-30, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death PULMONARY CONGESTION

Due to SARCOMA OF LUNG

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

470

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

23. Signature R. A. Michael Jr. (M.D. or other)

Address Springfield Mo. Date signed 10-31

1241

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Greene County Health Office,
County File Number 45-11-78
Date Filed 11-5-45

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 Ogle Stone Jr.

Licensed Embalmer No. 4176

P. O. Address Springfield

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.