

No. 2
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5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12905

FILED MAY 13 1946
Registration District No. 128

Primary Registration District No. 5466

Registrar's No. 350

1. PLACE OF DEATH:
 (a) County Greene
 (b) City or town Rural of Spring Campbell Twp
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Ozark Osteopathic Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether
 In this community 1 year
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. 401 W. Kearney St.
(If rural, give location)
 (e) Citizen of foreign country? No
(Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME FRANK C. POSPISHIL

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

7. Birth date of deceased July 23, 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>69</u>	<u>8</u>	<u>29</u>	hr. min.

9. Birthplace Cedar Rapids, Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business Fruit farm

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Alma Pospishil

(b) Address 401 W. Kearney St., Springfield, Mo.

17. (a) Removal (b) Date thereof April 24, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Cedar Rapids, Iowa

18. (a) Signature of funeral director Fred C. Thieme

(b) Address Springfield, Missouri

19. (a) 7-24-46 (b) B. M. Handy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22nd
 year 1946 hour 8:00 PM minute _____ M.

21. I hereby certify that I attended the deceased from Apr 1, 1946
 _____, 19____ to April 22, 1946
 that I last saw him alive on April 22, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Congestive heart failure Duration 3 WEEKS

Due to Chronic Myocarditis 2 YRS

Due to _____

Other conditions Typhoid - Gravis 5-7 YRS
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 93%

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 2'

23. Signature Melvin J. Conroy (M. D. or other) M.D.

Address Springfield, Mo. Date signed 4-23-46

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

MOTHER FATHER

MAY 16 1940

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 *Ralph H. Thieme*
Licensed Embalmer No. 3681
P. O. Address Springfield, 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.