

FILED SEP 18 1946
128

Registration District No.

Primary Registration District No. 2000

Registrar's No. 687

1. PLACE OF DEATH:

(a) County **GREENE**
Springfield

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

(c) Name of hospital or institution:
St. John's Hospital

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 days**. (Specify whether years, months or days)

In this community **2 days** (Specify whether years, months or days)

3. (a) PRINT FULL NAME

William Henry Holder, Jr.

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 **Infant**

6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive **X X** years

7. Birth date of deceased **8-16-46**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

0 0 2 - hr. **33** min.

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

10. Usual occupation **Infant**

11. Industry or business

12. Name **William Henry Holder**

13. Birthplace **Nixa Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Mable Lee Putney**

15. Birthplace **Springfield Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Wm. H. Holder**

(b) Address **Nixa - Mo.**

17. (a) **Burial** (b) Date thereof **8-19-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Nixa - Mo.**

18. (a) Signature of funeral director **T. W. MAPLES**

(b) Address **Clever - Mo.**

19. (a) **8-19-46** (b) **Dr. W. S. Handley**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Christian** 22

(c) City or town **Nixa** 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) 1
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **18**
year **46** hour **5** minute **10** A.M.

21. I hereby certify that I attended the deceased from **16 August 1946** to **18 August 1946**.
that I last saw him alive on **17 August 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **CEREBRAL DAMAGE #2** Duration **2 DAYS**

Due to **CEREBRAL ANOXEMIA.** **45 min.**

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED** PHYSICIAN

Of autopsy

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) (e) Means of injury 0

23. Signature **John P. Ferguson** (M. D. or other) **M.D.**
Address **732 Medical Arts Springfield Mo.** Date signed **18 Aug 46**

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..... *J. H. Maples*

Licensed Embalmer No. *2985*

P. O. Address *Clever 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*

Registration District No. 128

Primary Registration District No. 2000

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:
(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

3. (a) PRINT FULL NAME William H. Holderly

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 3

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years _____ hr. _____ min.

7. Birth date of deceased July 16, 1922
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1946 Under _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral damage due to temporary cerebral anoxemia Duration _____

Due to Difficult delivery

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature John P. Ferguson (M. D. or other) _____

Address 732 Medical Arts Bldg Date signed 11 Oct '46
Springfield, Mo.

SUPPLEMENTARY

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

880

