S. No. 2
M—5-42
r. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26912

FILED AUG 29 1946

Registration District No. ____ Primary Registration District No. 5466 Registrar's No. 665

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Rural - S. 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 ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Polk 84
(c) City or town Humansville
(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 ____

3. (a) PRINT FULL NAME Clifford Delton Storall
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 XX years
7. Birth date of deceased 8 (Month) 9 (Day) 1946 (Year)

8. AGE: Years — Months — Days — If less than one day 12 hr. — min.

9. Birthplace Springfield (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Infant
11. Industry or business ____

MOTHER FATHER
12. Name Chester Carl Storall
13. Birthplace Humansville (City, town, or county) Mo. (State or foreign country)
14. Maiden name Evelyn Lorene Chitwood
15. Birthplace Kansas City (City, town, or county) Kansas (State or foreign country)

16. (a) Informant Mrs Evelyn Fleenor (Sister)
(b) Address Humansville, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-46 (Month) (Day) (Year)
(c) Place: burial or cremation Humansville Mo
18. (a) Signature of funeral director Baker Funeral Home
(b) Address Fair Play, Mo.
19. (a) 8-10-46 (Date received local registrar) (b) S. N. S. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 10 year 1946 hour 8 30 a.m. minute — M.

21. I hereby certify that I attended the deceased from 8-9, 1946, to 8-10, 1946; that I last saw him alive on 8-10, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary atelectasis — Duration
Due to Two premature
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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature R. A. Michael M.D. (M. D. or other) D.D.
Address Springfield, Mo. Date signed 8-10-46

(Licensed Embalmer's Statement on Reverse Side)

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.