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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr. Stone

State File No. 30055

FILED OCT 10 1946

Local Registration District No. 1

Primary Registration District No. 5466

Registrar's No. 764

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution:
Ambulance enroute to Hospital 3
(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 Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Christian

(c) City or town Nixa, Missouri
(If outside city or town limits, write "RURAL")

(d) Street No. Route # 1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME James Harold Eoff

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Lois Eoff

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

7. Birth date of deceased August (Month) 27 (Day) 1924 (Year)

8. AGE: Years 22 Months 0 Days 24 If less than one day ..... hr. ..... min.

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

10. Usual occupation Farmer

11. Industry or business .....

MOTHER FATHER

12. Name James Everett Eoff

13. Birthplace Christian Co. (City, town, or county) Missouri (State or foreign country)

14. Maiden name Roba Walker

15. Birthplace Christian Co. (City, town, or county) Missouri (State or foreign country)

16. (a) Informant James Everett Eoff

(b) Address Route # 1 Nixa, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/46 (Month) (Day) (Year)

(c) Place: burial or cremation Payne Cemetery

18. (a) Signature of funeral director Herman H. Lohmeyer

(b) Address Springfield, Missouri

19. (a) 9-23-46 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 20 year 1946 hour 7 minute 30A.M.

21. I hereby certify that I attended the deceased from no physician in attendance to ....., 19..... ; that I last saw him ..... alive on ....., 19..... ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Shock & hemorrhage	
Due to: Fracture of skull	
Due to: Automobile accident	
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.

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22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident 133

(b) Date of occurrence Sept. 20 1946

(c) Where did injury occur? Springfield (City or town) Greene (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? City street (Specify type of place)

While at work? No (e) Means of injury Automobile

23. Signature Murray C. Stone Coroner (M. D. or other) 3

Address Springfield, Mo Date signed 9-21-46

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(Licensed Embalmer's Statement on Reverse Side)

DEC 16 1949

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

Roy H. Mercer Jr., Registered Apprentice No. 380,

working under my personal supervision.

Signed Walter E. Hamellar

Licensed Embalmer No. 3808

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.

X

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 061

Registration District No. 128 Primary Registration District No. 5466 Registrar's No. 764

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Ambulance enroute to Hospital
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Christian
(c) City or town Nixa - Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Rt. # 1
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James H Eoff
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 M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug 27 (Month) (Day) (Year)
8. AGE: Years 22 Months Days If less than one day hr. min.
9. Birthplace (City, town or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) N. E. Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 20 year 1946 hour minute M.
21. I hereby certify that I attended the deceased from 19 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	Duration
Due to	
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

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

30055