S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 28 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40303

Registration District No. 128 Primary Registration District No. 5466 Registrar's No. 981

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town S. Campbell Twp, Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Medical Center for Federal Prisoners 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 yrs, 2mos, 7 days (Specify whether
In this community 13 yrs, 2mos, 7 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Northern District of Indian Terr. (b) County 993
(c) City or town Muskogee 34
(If outside city or town limits, write "RURAL")
(d) Street No. Incarcerated since 1898 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME John PAINTER #21-H
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced married 1
6. (b) Name of husband or wife ?
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 23 (Day) 1868 (Year)

8. AGE: Years 76 Months 5 Days 14 If less than one day hr. min.

9. Birthplace Rockwell County (City, town, or county) Arkansas (State or foreign country) 1
10. Usual occupation Laborer
11. Industry or business
FATHER
12. Name (?) 0
13. Birthplace (City, town, or county) (State or foreign country) 1
MOTHER
14. Maiden name (?) 0
15. Birthplace (City, town, or county) (State or foreign country) 1
16. (a) Informant File
(b) Address MCFP
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/1946 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn Cemetery
18. (a) Signature of funeral director ALMA LOHMEYER FUNERAL HOME
(b) Address Springfield, Missouri
19. (a) 12/12/46 (Date received local registrar) (b) W E Hansley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 7
year 1946 hour 4 minute 45 A. M.
21. I hereby certify that I attended the deceased from September 30, 1933, to December 7, 1946
that I last saw him alive on December 7, 1946
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia, right, terminal	Approx. 1 day
Due to Hypertensive cardiovascular disease	11 yrs
Due to	
Other conditions Prostatic hypertrophy, benign (Include pregnancy within 3 months of death)	

Major findings:
Of operations 93D
Of autopsy As above, also dilatation of colon (Hirschsprung's disease) and generalized arteriosclerosis.

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 E W Moreland (M. D. XXXX)
Address Med. Center for Fed. Pris. Springfield, Missouri Date signed 12/10/46

111 (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. 3944

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.