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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. 834

FILED FEB 14 1947

Registration District No. 720

Primary Registration District No. 2000

Registrar's No. 80 A

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:
216 E. Madison
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 3 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

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

(d) Street No. 216 E Madison
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Theron Joseph Pope

3. (b) If veteran, name war No

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 Josephine Pope

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

7. Birth date of deceased Jan. (Month) 22 (Day) 1925 (Year)

8. AGE: Years	Months	Days	If less than one day
22	0	2	..... hr. ..... min.

9. Birthplace Stone County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation .....

11. Industry or business Queen City Wood Works

FATHER
12. Name Fred Pope
13. Birthplace Nixa (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Iva Merritt
15. Birthplace Stone County (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Josephine Pope
(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/47 (Month) (Day) (Year)
(c) Place: burial or cremation Union City, Mo.

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 1-27-47 (Date received local registrar) (b) W E Hardy MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 24 year 1947 hour 6 minute 2:00P M.

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

Immediate cause of death Suicide by firearms

Due to Shot self in head

Due to .....

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

Major findings:
Of operations .....
Of autopsy .....

Duration

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) Suicide

(b) Date of occurrence Jan. 24, 1947

(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?
In the home (Specify type of place)

While at work? No (e) Means of injury 22 rifle

23. Signature [illegible] C Stone, Coroner (M. D. or other) 3

Address Springfield, Mo Date signed 1-27-47

(Licensed Embalmer's Statement on Reverse Side)

111

APR 29 1947

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 Roy H. Mercer Jr.

Licensed Embalmer No. 4432

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.