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U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 28 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4561
State File No. _____
Registrar's No. 136

Registration District No. _____ Primary Registration District No. 2000

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

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:
Grant Street Baptist Church. 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community 40 Years
years, months or days

3. (a) PRINT FULL NAME Oliver M. Lemons

3. (b) If veteran, name war None

3. (c) Social Security No. 491-05-0302

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Millie D. Lemons

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased February 14, 1986
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
60	11	26	hr. _____ min.

9. Birthplace Dallas County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Laborer

12. Name William Lemons.

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

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Wm C. Lemons

(b) Address Springfield Mo.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 2/16/47
(Month) (Day) (Year)

(c) Place: burial or cremation Springfield

18. (a) Signature of funeral director J. H. Higgins & Co.

(b) Address Springfield Mo.

19. (a) 2-15-47
(Date received local registrar)

(b) W. S. Handy, M.D.
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo.

(b) County Greene 39

(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")

(d) Street No. 1124 N. Summit Ave. 6
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 12
year 1947 hour 3 minute 25 P.M.

21. I hereby certify that I attended the deceased from _____
No physician on attendance 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 Shock + hemorrhage.

Due to Fall from roof.

Due to _____

Other conditions 46A
(Include pregnancy within 3 months of death) 1039

Major findings: Of operations

Of autopsy _____

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

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

(b) Date of occurrence Feb. 12, 1947

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

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

While at work? Yes (e) Means of injury Fall

23. Signature Wm C. Lemons (M. D.) _____

Address Springfield Mo. Date signed 2-13-47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

APR 3 1948

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

Max Phobus

Licensed Embalmer No.

4091

P. O. Address

Springfield

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.