

No. 2
-12-45
5-17-39
X47370

State File No. 8717
Registrar's No. 176

FILED MAR 21 1947
128

Registration District No. 128

Primary Registration District No. 5466

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: 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)

2. USUAL RESIDENCE OF DECEASED:

(a) City or town Springfield State Mo.
(If outside city or town limits, write "RURAL")
 (b) County Greene
 (c) Street No. 1327 West Lynn St.,
(If rural, give location)
 (d) Citizen of foreign country? No. (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME William D. Lofftus

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 Widower

6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased: August 25 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>6</u>	<u>3</u>	hr. min.

9. Birthplace Warren Co. Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Farming

12. Name George Lofftus

13. Birthplace Unknown
(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 Mrs. May Towers

(b) Address Springdale Ark.

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

(b) Date thereof March 2, 1947
(Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director J.W. Klingner & Co.

(b) Address Springfield Mo.

19. (a) 2-28-47 (Date received local registrar)

(b) W. J. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 28
 year 1947 hour 5 minute 30 A. M.

21. I hereby certify that I attended the deceased from Feb 29 1947 to Feb 28 1947
 that I last saw him live on Feb 27 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death was Paralysis

Duration 4 months

Due to.....

Due to.....

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

Major findings: Of operations..... g3D

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?

23. Signature Dr. George W. Sanders
(Specify type of place) (e) Means of injury

Address 818 Sanders Bldg State signed.....

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.....

J. B. Klengner

Licensed Embalmer No.....

3358

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.