V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

State File No. 8840

Registration District No. FILED MAR 31 1947 Primary Registration District No. 3025 Registrar's No. 47

1. PLACE OF DEATH:
(a) County Howell
(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 Mo (b) County Howell 46
(c) City or town West Plains 1
(If outside city or town limits, write "RURAL")
(d) Street No. 3
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Glen Birchenough
3. (b) If veteran, name war
3. (c) Social Security No. 493-16-0243
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased unk. (Month) (Day) (Year)
8. AGE: Years unk. Months Days If less than one day hr. min.
9. Birthplace unk. (City, town, or county) 9 (State or foreign country)
10. Usual occupation Laborer 1
11. Industry or business
FATHER 12. Name unk.
13. Birthplace unk. 9 (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name unk.
15. Birthplace unk. 9 (City, town, or county) (State or foreign country)
16. (a) Informant 1
(b) Address
17. (a) B (Burial, cremation, or removal) (b) Date thereof 2-22-47 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Lawn
18. (a) Signature of funeral director Robertsons
(b) Address West
19. (a) Mar 18-1947 (Date received local registrar) (b) Beatrice Cook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 19 year 1947 hour minute M.
21. I hereby certify that I attended the deceased from 19 Feby, 1947, to 19 Feby, 1947; that I last saw him alive on 19 Feby, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchial Asthma	
Cardiac Failure	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 1 2	
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 Roger D. Smith (M. D. or other) M. D.
Address West Plains, Mo Date signed 4 Mar 47

379 (Licensed Embalmer's Statement on Reverse Side)

Rollin Smith

RECEIVED
District Health Officer No. 5,
District File Number 34116
Date Filed 3-28-47

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 George R. Drago, Registered Apprentice No. 431, working under my personal supervision.

Signed Paige D. Robertson

Licensed Embalmer No. 3432

P. O. Address West Plains 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.