

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 291

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: St. John's Hospital
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Christian ²²

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

(d) Street No. Route 1 Clever
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME William Race Hart

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W

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

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

7. Birth date of deceased: Mar. 27, 1947
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>0</u>	<u>0</u>	<u>11</u> hr. <u>0</u> min.

9. Birthplace: Springfield Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business Infant

12. Name Clinton Hart

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

14. Maiden name Wilmington

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

16. (a) Informant W. R. Hart

(b) Address Clever Mo. R-1

17. (a) burial (b) Date thereof Mar. 28-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frazier Chapel

18. (a) Signature of funeral director J. W. Maples

(b) Address Clever Mo.

19. (a) 3-28-47 (b) W. R. Handley MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 27
year 1947 hour 11 minute A. M.

21. I hereby certify that I attended the deceased from March 27, 1947 to March 27, 1947
that I last saw him alive on March 27, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Injury

Due to Labor

Due to _____

Other conditions (Include pregnancy within 3 months of death) 1600

Autopsy findings: Cesarean Section for delivery

Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. L. Johnston (M. D. or other) MD

Address Springfield, Mo Date signed 3/27/47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

39
2
6

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.

not embalmed

Signed _____

Licensed Embalmer No. _____

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.