

FILED JUN 9 1947

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 441

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: O'Reilly VA Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 32 Days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis Co.  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4808a Cote Brillante  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Cecil E. Harman

3. (b) If veteran, name war World War I 3. (c) Social Security No. 494-09-7390

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Minnie Harman 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased April 2, 1891  
(Month) (Day) (Year)

8. AGE: Years 56 Months 1 Days 25 If less than one day hr. \_\_\_\_\_ /min. \_\_\_\_\_

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

10. Usual occupation Machinist

11. Industry or business \_\_\_\_\_

12. Name Ernest Harman

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

14. Maiden name Sarah Cline  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Clinical Records

(b) Address Springfield, Mo.

17. (a) Removal (b) Date thereof 5/26/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo.

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 5-26-47 (b) W E Handley M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26 year 1947 hour 12 minute 43 A. M.

21. I hereby certify that I attended the deceased from May 26 1947 to May 26 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis, Chronic, Active, Far Advanced Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 150  
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 George J. Dusckas M.D.  
(Specify type of plane) (By means of injury)

23. Signature GEORGE J. DUSCKAS (M. D. or other) \_\_\_\_\_

Address O'Reilly VA Hospital Date signed 5-26-47

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

9  
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.

Signed *Paul F. Loney*

Licensed Embalmer No. *2457*

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.**