

FILED JUL 12 1947

8-20/124

5459

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Second Center
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: -----
(Specify whether
In this community 64 years
years, months or days)

3. (a) PRINT FULL NAME John Allen Helms

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

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

6. (b) Name of husband or wife Elsie (Mrs. Daniel) Helms 6. (c) Age of husband or wife if alive Wife 57 years

7. Birth date of deceased February 5th 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 3 28 hr. min.

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

10. Usual occupation Farmer

11. Industry or business Farm

12. Name Henry Helms

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

14. Maiden name Martha Rose

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

16. (a) Informant Elsie Helms

(b) Address Republic R.F.D.

17. (a) Burial (b) Date thereof July 7, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Yeakley, s chapel

18. (a) Signature of funeral director R.E. Thurman

(b) Address Republic Mo.

19. (a) 6-10-47 (b) Jewell Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39
(c) City or town Republic 0
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. 1 0
(If rural, give location)
(e) Citizen of foreign country? Yes No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3rd day June
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from May 31st to June 3rd, 1947
that I last saw him alive on June 2nd, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure Duration 3 wks

Due to Nephritis Pyra (?)

Due to _____

Other conditions (Include pregnancy within 3 months of death) 13/10

Major findings: Of operations None

Of autopsy None

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) Not
(b) Date of occurrence _____
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
None

While at work? No (Specify type of place) (e) Means of injury ✓

23. Signature B.F. Winder MD (M.D. or other)
Address Paris, Mo Date signed 6/5/47

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

Helms

MOTHER FATHER

9

0

0

0

RECEIVED

Greene County Health Office,

County File Number 47-2-66

Date Filed 2-10-47

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed RE Newman

Licensed Embalmer No. 503

P. O. Address Richfield, 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.