

S. No. 2
DM-5-43
v. 5-17-39
I X36671

FILED JUL 26 1947

Registration District No. _____ Primary Registration District No. **2000** Registrar's No. **607**

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:
707 N. Main (Nursing Home) 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 1/2 yrs.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Greene 39**

(c) City or town **Springfield 2**
(If outside city or town limits, write "RURAL")

(d) Street No. **707 N. Main Ave. 6**
(If rural, give location)

(e) Citizen of foreign country? **NO. 0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **John L. Willsie.**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **9**
year **1947** hour **8** minute **30 A.** M.

21. I hereby certify that I attended the deceased from **7, 8, 1947**, 19____, to **7, 9, 1947**, 19____;
that I last saw him alive on **7, 8, 1947**, 19____;
and that death occurred on the date and hour stated above.

4. Sex **Male 0** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Annie L. Willsie**

6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **April 30 1875**
(Month) (Day) (Year)

Immediate cause of death **Hemorrhage, cerebral** Duration **2 days**

Due to _____

Due to _____

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

8. AGE:	Years	Months	Days	If less than one day
	72	2	9	hr. min.

9. Birthplace **Ill. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Blacksmith Helper**

11. Industry or business **Blacksmith Helper**

12. Name **Govenous Willsie**

13. Birthplace **New York 1**
(City, town, or county) (State or foreign country)

14. Maiden name **Rebecca Edwards**

15. Birthplace **Pa. 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Annie E. Willsie**

(b) Address **Springfield Mo.**

17. (a) **Burial** (b) Date thereof **7-10-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **J. W. Klingner, F. Co.**

(b) Address **Springfield Mo.**

19. (a) **7-9-47** (b) **W. E. Handley MD**
(Date received local registrar) (Registrar's signature)

Major findings: **83A**

Of operations _____

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 **W. E. Handley** (M. D. or other) _____
Address **Springfield, Missouri** Date signed **7, 9, 47**

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

MOTHER FATHER

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. K. [Signature]

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.