

State File No. _____

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 669

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 Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days
 In this community 3 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Howell
 (c) City or town Mountain View (RURAL)
(If outside city or town limits, write "RURAL")
 (d) Street No. Route #2
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME CHARLES A. DUE
 3. (b) If veteran, name war WW I
 3. (c) Social Security No. _____

4. Sex Male 5. Color of race W
 6. (a) Single, widowed, married, divorced M /
 6. (b) Name of husband or wife Nancy Due
 6. (c) Age of husband or wife if alive 39 years
 7. Birth date of deceased Feb 28 1889
(Month) (Day) (Year)

8. AGE: Years 58 Months 5 Days 0
 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business Farmer

12. Name Elmer E. Due

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

14. Maiden name Rose Opal Gray
(City, town, or county) (State or foreign country)

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

16. (a) Informant Correspondence Records

(b) Address O'Reilly VA Hospital

17. (a) Burial (b) Date thereof July 30, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cem. Springfield, Mo

18. (a) Signature of funeral director Norman Delaney, John Bone
 (b) Address Springfield, Mo

19. (a) 7-29-47 (b) W E Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 27
 year 1947 hour 2 minute 00 P. M.

21. I hereby certify that I attended the deceased from July 25, 1947, to July 27, 1947, that I last saw him alive on July 27, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia, type and organism undetermined
 Duration 2 days

Due to _____
 Due to _____

Other conditions Coronary arteriosclerosis Unk
(Include pregnancy within 3 months of death)

Major findings: Internal strangulated inguinal hernia, left, herniorrhaphy of
Of operations
 Of autopsy Same as above
 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? _____

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

23. Signature PAUL L. EISELE (M. D. or other) _____
 Address O'Reilly VA Hospital Date signed 7/27/47
 Clinical Director

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 *L. Dean Gorman*

Licensed Embalmer No. *3177*

P. O. Address *Springfield MS*

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.