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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 20 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27432

State File No. _____

Registration District No. 128

Primary Registration District No. 2100

Registrar's No. 662

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 Hosp., Springfield, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 106 days
(Specify whether years, months or days)

In this community 106 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Oklahoma (b) County Oklahoma ⁹⁹⁹

(c) City or town Edmond ³⁴
(If outside city or town limits, write "RURAL")

(d) Street No. 712 E. Hurd
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) ²
If yes, name country _____

3. (a) PRINT FULL NAME Aldon B. Viers

3. (b) If veteran, name war WWII

3. (c) Social Security No. 273163284

4. Sex male 5. Color or race W

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

6. (b) Name of husband or wife Gwen Viers

6. (c) Age of husband or wife if alive 21 yr years

7. Birth date of deceased April 26 1920
(Month) (Day) (Year)

8. AGE: 27 Years Months 2 Days 29 If less than one day
hr. min.

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

10. Usual occupation Taxi Driver

11. Industry or business _____

12. Name August Viers

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

14. Maiden name Marion B. Hartman
(City, town, or county) (State or foreign country)

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

16. (a) Informant Clinical Records

(b) Address O'Reilly VAH, Springfield, Mo.

17. (a) Removal (b) Date thereof July 28-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edmond, Okla.

18. (a) Signature of funeral director Gorman Beharff Tuman
(City, town, or county) (State or foreign country)

(b) Address Springfield Mo

19. (a) 7-25-47 (b) W E Handley MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 25 day
year 1947 hour 6 minute 10 a.m.

21. I hereby certify that I attended the deceased from April 11, 1947
to July 25, 1947

that I last saw him alive on July 25, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, Pulmonary, chronic, far advanced, active

Due to _____

Due to _____

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

Major findings:
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? _____

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

23. Signature Paul E. Cash (M. D. or other) 0 ✓

Address O'Reilly VAH, Springfield, Mo. Date signed 7-25-47

(Licensed Embalmers' Statement on Reverse Side)

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

34
2
16

OCT 3 1949

OCT 14 1949

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. Evelyn Gorman*

Licensed Embalmer No. *3177*

P. O. Address *Springfield, 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.