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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 27 1947
Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34231
Registrar's No. 876
Primary Registration District No. 2000

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

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution: City Hospital
(If outside city or town limits, write "RURAL" and name of township)
(If in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 1/2 days
Specify whether
In this community _____
years, months or days

3. (a) PRINT FULL NAME FRANK WHITFIELD
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex M
5. Color of race Negro
6. (a) Single, widowed, married, divorced 9
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased unknown 1875
(Month) (Day) (Year)

8. AGE: Years 72 Months ? Days ?
If less than one day _____ hr. _____ min.

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

10. Usual occupation Janitor

11. Industry or business _____

12. Name Unknown
13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Belle Holmes
(b) Address 600 - N. Weaver

17. (a) Burial (b) Date thereof 10-9-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hagleywood

18. (a) Signature of funeral director W. V. Smith
(b) Address 702 N. Jefferson

19. (a) 10-9-47 (b) W. J. Handley
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 600 - N. Weaver
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 10 day 5
year 1947 hour 12 minute 30 A.M.
21. I hereby certify that I attended the deceased from Dec 24
1946, to Oct 5 1947.
that I last saw him alive on Oct 5 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism
Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 8 months of death)

Major findings:
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? _____

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

23. Signature Lemard Brown (M. D. or other)
Address 311 1/2 Boonville Date signed Oct 8 1947

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..... *Herbert V Smith*.....

Licensed Embalmer No. *4256*

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.