

FILED DEC 12 1947

State File No. _____

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1017

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield mo
(c) Name of hospital or institution St John Hosp
(d) Length of stay: In hospital or institution 28 days
In this community 28 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Haskell 46
(c) City or town Pomona
(d) Street No. _____
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Baltz, DR. ~~EA~~ Thomas Albert

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

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

6. (b) Name of husband or wife Sarah P. Baltz 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Nov. 13 1872

8. AGE: Years 75 Months 0 Days 11 hr. _____ min.

9. Birthplace Sylvan -Pa.

10. Usual occupation _____

11. Industry or business Physician

12. Name Thomas Baltz

13. Birthplace Unknown Pa.

14. Maiden name Margaret Gearhart

15. Birthplace unknown Md.

16. (a) Informant Mrs. T. A. Baltz

(b) Address Pomona, Missouri

17. (a) Removal (b) Date thereof 11-24-47

(c) Place: burial or cremation Pomona, Mo.

18. (a) Signature of funeral director Edman Behring

(b) Address Springfield mo

19. (a) 11/24/47 (b) W.E. Haskell MD

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 24 year 1947 hour 9:30 minute AM

21. I hereby certify that I attended the deceased from 10-26-47 to 11-24-47 that I last saw him alive on 11-23-47 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart Disease & coronary occlusion
Th. Arterial occlusion left femoral artery

Due to Th. Bronchiogenic carcinoma L.U.

Due to Th. left upper lobectomy 11-15-47

Other conditions (include pregnancy within 3 months of death)

Major findings: Ca. L.U.L. 7R

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? _____

(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 Paul G. Schuster (M. D. or other) _____

Address 805 Woodliff Blvd Date signed 11-24-47

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

1031

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. Dublin 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.