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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 27 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29450
Registrar's No. 797

Registration District No. _____ Primary Registration District No. 2000

1. PLACE OF DEATH: GREENE
(a) County Springfield
(b) City or town Springfield
(c) Name of hospital or institution: Springfield Baptist Hospital
(d) Length of stay: In hospital or institution 12 days
In this community 12 days

3. (a) PRINT FULL NAME Darnell, Mr. Elmo
(b) If veteran, name war none
(c) Social Security No. none

4. Sex male
5. Color or race WHITE
6. (a) Single, widowed, married, divorced married
(b) Name of husband or wife Etha Jones
(c) Age of husband or wife if alive 68 years
7. Birth date of deceased Oct 30 1880

8. AGE: Years 67 Months 10 Days 22
If less than one day hr. min.

9. Birthplace Laclede Co. Mo. 13
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farm

12. Name Robert Darnell
13. Birthplace Unknown Va. 1
(City, town, or county) (State or foreign country)

14. Maiden name Mollie Sarver
15. Birthplace Unknown Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Omer Darnell (son)

(b) Address Lebanon Mo

17. (a) Burial (b) Date thereof 9-25-48
(c) Place: burial or cremation oakland mo

18. (a) Signature of funeral director W.E. Helman
(b) Address Lebanon, Mo.

19. (a) 9-24-48 (b) W.E. Handley M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede
(c) City or town Rural - Lebanon
(d) Street No. R#1
(e) Citizen of foreign country? no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 22nd
year 1948 hour 2 minute 10 P.M.
21. I hereby certify that I attended the deceased from Sept 11 1948 to Sept 22 1948
that I last saw him alive on Sept 22 1948
and that death occurred on the date and hour stated above.

Immediate cause of death:
1 Coronary occlusion
2 Fracture of hip

Due to _____
Due to _____

Other conditions General paresis
(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? _____
(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 Phyllancy (M. D. or other)
Address Springfield Mo Date signed 22 Sept 48

Duration 30 1/2 weeks
Several years
PHYSICIAN
Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

MOTHER FATHER

OCT 24 1956

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, 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.

Registration District No. 128

Primary Registration District No. 2000

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:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Elmo Darnell

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Oct 30
(Month) (Day) (Year)

8. AGE: Years 67 Months 10 Days _____ (Less than one day)
hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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 _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1948 hour _____ minute _____ M. 2

21. I hereby certify that I attended the deceased from _____ to _____
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

PHYSICIAN

Of autopsy accident no relation to death
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) accident

(b) Date of occurrence Sept 4 1948

(c) Where did injury occur? Lebanon no
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Street

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed no

SUPPLEMENTARY

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

S-29450