

Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution: Springfield Baptist Hospital
(d) Length of stay: In hospital or institution 24 hrs
In this community 24 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County DALLAS 34
(c) City or town Fair Grove
(d) Street No. Fair Grove Rd 1
(e) Citizen of foreign country? NO

3. (a) PRINT FULL NAME Andy Ben Pfeifer
(b) If veteran, name war No.
(c) Social Security No.

4. Sex M (b) Color or race WHITE
(c) Name of husband or wife: Nannie Pfeifer
(d) Birth date of deceased: June 25 1878

5. AGE: Years 70 Months 4 Days 17
If less than one day hr. min.

6. Birthplace: Dallas Mo.
Usual occupation: Farmer

MOTHER FATHER
12. Name: G.W. Pfeifer
13. Birthplace: MO.
14. Maiden name: unknown
15. Birthplace: ?

16. (a) Informant: Nannie Pfeifer
(b) Address: Fair Grove Mo.
(c) Date thereof: 11-14-1948
(d) Place: burial or cremation: Mt Olive
(e) Signature of funeral director: Montgomery
(f) Address: Buffalo Mo.
(g) Date received local registrar: 11-16-48
(h) Signature: W.E. Handley M.D.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 12
year 1948 hour 4 minute 8 M.
21. I hereby certify that I attended the deceased from Nov. 11 1948 to Nov. 12 1948
that I last saw him alive on Nov. 12 1948
and that death occurred on the date and hour stated above.

Immediate cause of death: Branchiopneumonia
Due to: Generalized arteriosclerosis

Other conditions: (Include pregnancy within 3 months of death)
Major findings: None

Of autopsy: none
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): none
(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)
Signature: Williams & Paul (M.D. or other)
Address: Springfield, Mo. Date signed: 11/13/48

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 Clyde Montgomery
Licensed Embalmer No. 3592

P. O. Address Buffalo, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec
Registrar's No. 995-

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Sheep

(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Andy B. Pfeifer

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 m

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

7. Birth date of deceased June 25
(Month) (Day) (Year)

8. AGE: Years 20 Months _____ Days _____ (less than one day) hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____ (State or foreign country)

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) W. H. Handley
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Year 1948 hour _____ minute _____ M.

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

Due to _____

Due to _____

Other conditions _____ (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? _____

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

S-36194