

THE DIVISION OF HEALTH OF MISSOURI,  
STANDARD CERTIFICATE OF DEATH

State File No. **33250**  
**9.38**

BIRTH NO. **NOV 13 1951** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **9.38**

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>	c. LENGTH OF RESIDENCE (If not in institution) <b>2 1/2</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield, Mo</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>1707 W. Lee St.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>William</b> b. (Middle) <b>H.</b> c. (Last) <b>NULL</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 2, 1951</b>
--------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------

5. SEX <b>MALE M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Feb. 23, 1890</b>	9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 1 MIN. Min.
----------------------	-------------------------------	---------------------------------------------------------------------------	------------------------------------------	-------------------------------------------	---------------------------	-------------------------	-------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Buffalo Valley, Tenn. /</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
------------------------------------------------------------------------------------------------------------	--------------------------------------------------	-----------------------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME <b>unknown</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Divorced</b>
--------------------------------------	---------------------------------------------	------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>	16. SOCIAL SECURITY NO. <b>4663-2122</b>	17. INFORMANT'S SIGNATURE OR NAME <b>VA Hospital, Springfield, Mo.</b>	ADDRESS
-----------------------------------------------------------------------------------------------------------------------------	---------------------------------------------	---------------------------------------------------------------------------	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary tuberculosis, active, chronic, far advanced.</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>002X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	-------------------------------------------------	-------------------------------------------------------------------------------------

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------------

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <b>VA</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
-----------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from **Feb. 9, 1947**, to **Nov. 2, 1951**, and that death occurred at **5:30P** m., from the causes and on the date stated above.

23a. SIGNATURE <b>A. J. Bondurant, M.D., Acting Chief, Professional Services,</b>	(Degree or title)	23b. ADDRESS <b>VA Hospital, Springfield, Mo.</b>	23c. DATE SIGNED
--------------------------------------------------------------------------------------	-------------------	------------------------------------------------------	------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>11-5-51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Springfield, Mo</b>
------------------------------------------------------------	-----------------------------	----------------------------------------------------------------	-------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <b>11-5-51</b>	REGISTRAR'S SIGNATURE <b>W. J. Handley</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J.W. Klingner &amp; Co. Spfld. Mo.</b>	ADDRESS
--------------------------------------------	-----------------------------------------------	-------------------------------------------------------------------------------	---------

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

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Max Rhodes*  
Licensed Embalmer No. 407  
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.