

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4618**

FILED MAR 10 1952

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 207

396

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Mississippi	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Charleston, 0672	
c. LENGTH OF STAY (in this place) 334 days		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Leo	b. (Middle) (NMI)	c. (Last) Hale	4. DATE OF DEATH (Month) (Day) (Year) March 1, 1952
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH November 26, 1909	9. AGE (In years last birthday) 42	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Mill Creek, Ill.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Scena Lee Hale
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME VA Hospital Records, Springfield, Mo.	ADDRESS
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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, asphyxia, 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) Tuberculosis, Pulmonary, bilateral cavitary extensive.	ANTECEDENT CAUSES DUE TO (b) Cor Pulmonale. Active Potts disease, 1st. to 5th dorsal vertebrae. DUE TO (c) dorsal vertebrae.		
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 0120	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **April 2, 1951**, to **March 1, 1952**, and that death occurred at **9:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE W. F. Culbertson, M.D., Manager	23b. ADDRESS VA Hospital, Springfield, Mo.	23c. DATE SIGNED 3/2/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE March 6, 1952	24c. NAME OF CEMETERY OR CREMATORY National	24d. LOCATION (City, town, or county) (State) Springfield, Mo.
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DATE REC'D BY LOCAL REG. 3-5-52	REGISTRAR'S SIGNATURE James H. Amor, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Alma Schreyer	ADDRESS Springfield, Mo.
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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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....

Gene C. Hunter

Signed.....

Student Embalmer

Licensed Embalmer No. *4739*

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.