

S. No. 2  
-12-45  
5-17-39  
PI X47070

FILED AUG 20, 1947  
Registration District No. **28**

Primary Registration District No. **2000**

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

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:  
**1936 East Ave. 1**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **11 Years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**

(c) City or town **Springfield**  
(If outside city or town limits, write "RURAL")

(d) Street No. **1936 East Ave.**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **William Henderson Ardrey**

3. (b) If veteran, name war **No**

3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widower**

6. (b) Name of husband or wife **not given**

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **June 1 st. 1875**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>72</b>	<b>1</b>	<b>30</b>	hr. _____ min. _____

9. Birthplace: **Ill.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name **Thomas Ardrey**

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

14. Maiden name **Unknown**

15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **F. R. Ardrey**  
(b) Address **414 N. Oakland, Mt. Grove, Mo.**

17. (a) **Burial** (b) Date thereof **Aug 3, 1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Payne Cemetery**

18. (a) Signature of funeral director **W. L. Dunn**  
(b) Address **Springfield, Mo.**

19. (a) **8-2-47** (b) **W. L. Dunn**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **31** st. year **1947** hour **4** minute **12** P.M.

21. I hereby certify that I attended the deceased from **July 28** 19**47**, to **July 30** 19**47**, that I last saw him alive on **July 30** 19**47**, and that death occurred on the date and hour stated above.

Immediate cause of death **Diabetic coma**

Due to **Diabetes Mellitus**

Other conditions **Arterio sclerosis**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy **(6)**

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? \_\_\_\_\_

23. Signature **M. D. Gentry** (M. D. or other) \_\_\_\_\_  
Address **Med Arts Bldg** Date signed **8-1-47**

Duration **2 da**

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*A. J. Mc Cann*

Licensed Embalmer No. 3727

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.**