

28 1936

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

8419

1. PLACE OF DEATH

County L. Greene Registration District No. 324  
Township Robberson Primary Registration District No. 5449  
City Springfield (No. R.# 5)

File No. \_\_\_\_\_  
Registered No. 3  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Carl Wayne Joller  
(Usual place of abode) Willard Mo St. R.# 7 Ward \_\_\_\_\_

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Feb 10 - 1930

7. AGE

YEARS  
0

MONTHS  
0

DAYS  
25

IF LESS than I day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Infant at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

R. B. Joller

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ind.

12. MAIDEN NAME OF MOTHER

Lucile Mang

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14. INFORMANT

(Address)

R. B. Joller  
Willard Mo R.# 7

15. FILED

Mar 20 1936

Mae Sarbarn

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

3 1 1936

17.

I HEREBY CERTIFY, That I attended deceased from 3/1, 1936, to 3/9, 1936, that I last saw him alive on 3/6, 1936, and that death occurred, on the date stated above, at \_\_\_\_\_.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Congenital maldigestion in breast

CONTRIBUTORY (SECONDARY)

1590

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

no

DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

R. F. Thompson, M. D.

3/30, 1936 (Address) Springfield Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Robinson Prairie Cemetery Mar 7 1936

20. UNDERTAKER

ADDRESS

J. H. Klingner 424 E. Com. Springfield, Mo.

X. E.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

...may be present...  
...Exact amount of O...  
...EXACTLY...  
...Every item of information should be checked and...  
...ON STATE...

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
 FOR MUST BE WRITTEN ON  
 THIS SUPPLEMENTARY.

3/30

1. PLACE OF DEATH.  
 County Greene Registration District No. 224 File No. 8419  
 Township Johnson Primary Registration District No. 2449 Registered No. 3  
 City..... (No. R# 5)..... St. .... Ward)

2. FULL NAME Carl Wayne Jeller  
Hillard No. R# 2  
 (a) Residence. No. .... (If nonresident give city or town and State)  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S.  
(Write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 6 1930

17. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19....., 19....., 19....., and that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

..... (duration) ..... yrs. .... mos. .... da.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. .... mos. .... da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
 WAS THERE AN AUTOPSY.....  
 WHAT TEST CONFIRMED DIAGNOSIS.....  
 (Signed)....., M. D.  
 , 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT (Address)

15. FILED 3/20 1930 Mae Sanborn REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19

20. UNDERTAKER ADDRESS

N. ... information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

6168-5