

REC'D APR 13 1939

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

10834
Do not use this space.

1. PLACE OF DEATH
 (a) County GREENE Registration District No. 318
 (b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 247A
 (c) City SPRINGFIELD (d) Street No. 582 W Chestnut St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Robert Gellbraith
 (a) Residence, No. 582 W Chestnut St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Alice (dec 1931)
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 10, 1864
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 11 11
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Gardner
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Brook, Indiana
 FATHER 13. NAME unk
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk
 MOTHER 15. MAIDEN NAME Data. unk
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk
 17. INFORMANT (ADDRESS) Mrs. Robert West Springfield Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Hayelwood DATE 3/26 39
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alma Phoney Springfield Mo
 20. FILED Mar 26 1939 Chas. George Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 21, 1939
 22. I HEREBY CERTIFY, That I attended deceased from in West, 1939, to Mar 21, 1939, 1939.
 I last saw him alive on Mar 21, 1939. Death is said to have occurred on the date stated above, at 10 A. m.
 The principal cause of death and related causes of importance were as follows:
Rifle shot right temple
Suicide
 Date of onset 16/7
 Other contributory causes of importance:
 Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? no
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Suicide Date of injury 1939
 Where did injury occur? home
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury Rifle shot in home
 Nature of injury in temple
 24. Was disease or injury in any way related to occupation of deceased?
 If so, specify.....
 (Signed) J. P. Ferguson, M. D.
 (Address) 604 E. Elm

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.