

330 AUG 16 1939

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

26330
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 55
(b) Township Anderson Primary Registration District No. 6202
(c) City Pidaca (d) Street No. _____ 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. 2 hrs. How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

ROBERT JAMES MOTES
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-2-1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 2 hrs. or 2 min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
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) St. Louis (STATE OR COUNTRY) Mo.

FATHER 13. NAME Andrew Motes

14. BIRTHPLACE (CITY OR TOWN) Ballwin, Mo. (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Sadie Smith

16. BIRTHPLACE (CITY OR TOWN) Mulville, Mo. (STATE OR COUNTRY)

17. INFORMANT Andrew Motes (ADDRESS) Ballwin, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Paul's Ep. Ch. 7-25-39 DATE

19. FUNERAL DIRECTOR (NAME) W. V. Munn (ADDRESS) Ballwin, Mo.

20. FILED July 26 1939 W. V. Munn Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/27/39 19

22. I HEREBY CERTIFY, That I attended deceased from 7/27/39 19, to 7/27/39 19.

I last saw h. alive on 7/27/39 19. Death is said to have occurred on the date stated above, at 6:00 m.

The principal cause of death and related causes of importance were as follows:

Immaturity. Date of onset _____

Other contributory causes of importance: 154

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Stephens, M. D.

(Address) Ballwin, Mo.

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.

RECEIVED

District Health Officer No. 2,
District Health Officer No. 2,

District File Number 989-138

District File Number 989-138

Date Filed 8-14

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 con
with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, above space should be left blank.