

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.

RECD NOV 18 1939

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

**36168**  
Do not use this space.

1. PLACE OF DEATH *21*

(a) County *Lundy* Registration District No. *328*

(b) Township *Salem* Primary Registration District No. *5459* Registered No. \_\_\_\_\_

(c) City *Salem* (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) \_\_\_\_\_ St.

(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 *Stellborn*

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *7* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) \_\_\_\_\_

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 21 - 1939*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ 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 \_\_\_\_\_

FATHER 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

13. NAME *Leo Robertson*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

MOTHER 15. MAIDEN NAME *Stella Mitchell*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

17. INFORMANT (ADDRESS) *Leo Robertson*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Salem Co* DATE *July 21* 19*39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Lippards*

20. FILED *7 21 39 June Fair* Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *about July 20, 1939*

22. I HEREBY CERTIFY, That I attended deceased from *not at all* to \_\_\_\_\_, 19\_\_\_\_

I last saw him *never* \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at *2 P* m.

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

*Stellborn*

Date of onset *7-20-39*

Other contributory causes of importance: *None*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? *Clinical* 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? *No*

If so, specify *DR Rooks* \_\_\_\_\_, M. D.

(Signed) *DR Rooks* \_\_\_\_\_

302 (Address) *Salem Mo*

RECEIVED

District Health Officer No. 11,

District File No. 1129-1591

Date Filed NOV 16 1939

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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.....

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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

36168  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Grundy Registration District No. 328  
 (b) Township Greentown Primary Registration District No. 5459 Registered No. ....  
 (c) City ..... (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. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Stillborn  
 (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 F 4. COLOR OR RACE W 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) 7-21-1939

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

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) (STATE OR COUNTRY) .....

FATHER  
 13. NAME .....  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

MOTHER  
 15. MAIDEN NAME .....  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

17. INFORMANT (ADDRESS) .....

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

19. FUNERAL DIRECTOR (ADDRESS) .....

20. FILED 1-12 1940 Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-20-1939

22. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19.....  
 I last saw h. .... alive on ..... 19..... Death is said to have occurred on the date stated above, at..... m.  
 The principal cause of death and related causes of importance were as follows:  
 Date of onset

Other contributory causes of importance: .....

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) O. R. Rooper M. D.  
 (Address) Greentown Mo.

SUPPLEMENTARY

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

