

36978

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. 189

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Moberly

(c) Name of hospital or institution: Wabash Hospital
(If not in hospital or institution, write street number or location)

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

In this community Twenty Four years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph

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

(d) Street No. 301 North Buchanan
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME ROBERT LESTER WHITE

3. (b) If veteran, name war None

3. (c) Social Security No. 702-05-3417

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day First year 1939 hour Two minute Twenty AM.

21. I hereby certify that I attended the deceased from September 6, 1939 to October 1, 1939; that I last saw him alive on October 1, 1939 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary White 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased April - 2 - 1879
(Month) (Day) (Year)

Immediate cause of death Bronchitis, Chronic

Due to Acute exacerbation of above

Other conditions Infected right thumb
(Include pregnancy within 3 months of death)

Major findings: Infected right thumb

Of operations _____

Of autopsy None

8. AGE: Years 60 Months 5 Days 29 If less than one day hr. _____ min. _____

Duration Several years

9. Birthplace Saline Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Engine Wiper Wabash Shop

11. Industry or business _____

12. Name William White

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

14. Maiden name Mary Watts

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

16. (a) Informant's own signature Mrs Mary White

(b) Address 301 North Buchanan

17. (a) Burial (b) Date thereof Oct-3-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly, Randall Cem.

18. (a) Signature of funeral director Super Funeral Home

(b) Address Moberly Mo.

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. D. Steeler (M. D. or other) M.D.

Address Moberly, Mo. Date signed _____

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

MARGIN RESERVED FOR BINDING
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.

Rev. 5-17-39
50M-5-17-39
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1062

RECEIVED

District Health Officer No. 10

District File Number 11-39-1950

Date Filed NOV 15 1939

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 myself
and R. M. Gater, Registered Apprentice No. 185
working under my personal supervision.

Signed Chas G. Barnes

Licensed Embalmer No. 2414

P. O. Address Woburn Ave

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

36978
Do not use this space.

1. PLACE OF DEATH
 (a) County Randolph Registration District No. 735-
 (b) Township Moberly Primary Registration District No. 3034 Registered No. 189
 (c) City Moberly (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 Robert Lester White
 (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 (write the word) m

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.
	<u>60</u>	<u>5</u>	<u>29</u>	

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) (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 _____ 19. _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 1 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw him _____ 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:
Brain Thrombosis, Chronic myocarditis, at the expiration of above

Other contributory causes of importance: infected at the time

Name of operation Right thumb tends sheath drained Date of Sept. 29, 1939

What test confirmed diagnosis? Operation Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? accident Date of injury Sept. 20, 1939
 Where did injury occur? Moberly, Mo.
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. Industry
 Manner of injury Ran reflector in right thumb. Removed
 Nature of injury at himself. Infection followed.

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify R. D. Streetor, M. D.
 (Address) Moberly, Mo.

SUPPLEMENT

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Local Registrar.

