

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

37462
Do not use this space.

NOV 24 1939

1. PLACE OF DEATH (a) County Vernon - 2 Registration District No. 875
 (b) Township Leatic Primary Registration District No. 3039 Registered No. 273
 (c) City or Nevada - 1 (d) Street No. _____ St.
 (e) Length of residence in city or town where death occurred _____ (If death occurred in Hospital or Institution, write its name instead of street and number)
 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME 5911 Robert Lee Means
 (a) Residence, No. 805 A Spring St 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown -
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
about 83 ✓ - -

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Labourer -
 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 Moore Cem. DATE Nov. 3 - 1939

19. FUNERAL DIRECTOR (NAME) Eichinger Funeral Home
 (ADDRESS) Nevada, MO

20. FILED _____ 19 _____
 Local Registrar. X 795

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 1939
 22. HEREBY CERTIFY, That I attended deceased on Nov 1 1939, to _____, 19____
 I last saw him alive on Nov 1 1939 Death is said to have occurred on the date stated above, at 6:40 p.m.
 The principal cause of death and related causes of importance were as follows:

Cornary occlusion
Arteriosclerosis
 Date of onset Mar 1, 1939
80 74

Other contributory causes of importance: _____
 Name of operation none Date of _____
 What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury _____, 19____
 Where did injury occur? none (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 none

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) R W Pearce M. D.
 (Address) Nevada, 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.

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WRITE PLAINLY, WITH OUTFIELDING INFORMATION

1 X16065

RECEIVED

District Health Officer No. 7,
District File Number 9-39-1288-
Date Filed 11-1-39

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 Marsh. Eichinger
Licensed Embalmer No. 26576
P. O. Address Nevada, Mo.

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.