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

Do not use this space.

File No. 8313

Registered No.

1. PLACE OF DEATH
County Shannon. Registration District No. 8-4
Township Primary Registration District No. (4)
City Birch Tree Mo. (No.) St. Ward)

2. FULL NAME Robert E. Lee Best.
(a) Residence, No. Owls Bend Mo. Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Etta Best
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): April 9-1880.
7. AGE: YEARS 59 | MONTHS 10 | DAYS 28 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Farmer.
9. Industry or business in which work was done, as silk mill, 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): Missouri
FATHER
13. NAME: Silas Best.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mt Knowon Ky
MOTHER
15. MAIDEN NAME: Mary Taylor.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo.
17. INFORMANT (ADDRESS): Etta Best Owls Bend Mo.
18. BURIAL, CREMATION, OR REMOVAL: Birch Tree DATE Mch 6 1940
19. UNDERTAKER (ADDRESS): A. L. Inman Winona Mo.
20. FILED 3-4-1940 Frank Hyde M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Mch 4 1940.
22. I HEREBY CERTIFY, That I attended deceased from Jan 1940, to Mar 1940
I last saw h— alive on Feb 13 1940. Death is said to have occurred on the date stated above, at 1-P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of Stomach	

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) Frank Hyde, M. D.
(Address) Eunice 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.

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

20M-2-19-36 X7294

RECEIVED
District Health Officer No. 5,
Issued File Number 340352
Date Filed 3-2-40

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8313

Registration District No. 824 Primary Registration District No. 6077 Registrar's No.

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

1. PLACE OF DEATH
(a) County Shannon
(b) ~~City or town~~ Franciscan Iron
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Robert E. Lee Best
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased apr (Month) 9 (Day) 1880 (Year)

8. AGE: Years 59 Months 10 Days 25 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 3-4-40 (Date received local registrar) (b) Frank Hyde MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mch day 4
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

23. Signature Frank Hyde (M. D. or other)
Address Commerce Date signed

SUPPLEMENTARY