

Registration District No. 508

Primary Registration District No. 3026

Registrar's No. 87

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Shillito Mo
(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 mo (b) County Linn
(c) City or town Shillito Mo
(d) Street No. 406 Elm St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME ROBERT R. REA MD

8. (b) If veteran, name war no 8. (c) Social Security No. no

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife If alive _____ years

7. Birth date of deceased May 6 - 1897
(Month) (Day) (Year)

8. AGE: Years 83 Months 00 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace Iowa (City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name David Rea

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

14. Maiden name Anna Shillito

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

16. (a) Informant Emma Rea

(b) Address Shillito Mo

17. (a) 406 Elm St (b) Date thereof July 7, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jamesport Mo

18. (a) Signature of funeral director Jamesport Mo

(b) Address Jamesport Mo

19. (a) 7-5-40 (b) H. M. Grace MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5
year 1940 Hour 12 minutes 50 M.

21. I hereby certify that I attended the deceased from 5-7 1940, to July 5 1940
that I last saw him alive on 7-4 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus

Due to 5 1/2

Due to _____

Other conditions Artero-sclerosis
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 M.D.

23. Signature Hubert Syney M.D. (M. D. or other) 7-5-1940
Address Shillito Mo Date signed

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

1912
1879

RECEIVED

District Health Officer No. 11,

District File Number 740-1175

Date Filed JUL 9 1940

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 D. L. Robinson

Licensed Embalmer No. 3244

P. O. Address Geneport, 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.