

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. 217

1. PLACE OF DEATH:

- (a) County Callaway
- (b) City or town Fulton Mo.
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: State Hospital #1
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution 25 years
(Specify whether)
- In this community 210
years, months or days

3. (a) PRINT FULL NAME ROBERT ANDREW NESBY

3. (b) If veteran, no name war
3. (c) Social Security No. none

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife D.K. 6. (c) Age of husband or wife if alive years

7. Birth date of deceased D.K.
(Month) (Day) (Year)

8. AGE: Years about 56 Months Days If less than one day
hr. min.

9. Birthplace Ark. (City, town, or county) (State or foreign country)10. Usual occupation Laborer

11. Industry or business

12. Name D.K.
13. Birthplace Miss. (City, town, or county) (State or foreign country)
14. Maiden name D.K.
15. Birthplace D.K. (City, town, or county) (State or foreign country)

16. (a) Informant State Hospital Record

- (b) Address Fulton Mo.
17. (a) Removal (b) Date thereof Sept 3, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Mo18. (a) Signature of funeral director J. O. Roberts(b) Address Columbia Mo

19. (a) Sept 3, 1940 (b) A. N. Crews
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County Butler
- (c) City or town Poplar Bluff Mo.
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 30 day Aug.
year 1940 hour 1 minute 06 A.M.

21. I hereby certify that I attended the deceased from Aug. 1, 1938, to Aug 30, 1940;
that I last saw him alive on Aug. 29, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Acute Myocarditis

Due to _____

Due to 134Other conditions Renal Calculi
(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) no
- (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 M. K. Pope (M. D. or other) _____Address State Hospital #1 Fulton Mo. Date signed 8/30/40

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 complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.