

Registration District No. **318**

Primary Registration District No. **2001**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **City Hospital**
(If not a 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 1/2**

3. (a) PRINT FULL NAME **Robert David Weatherman**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive **XX** years

7. Birth date of deceased **April 25, 1923**
(Month) (Day) (Year)

8. AGE: Years **17** Months **4** Days **0** If less than one day _____ hr. _____ min.

9. Birthplace **Springfield Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Student**

11. Industry or business **at school**

12. Name **William Weatherman**

13. Birthplace **Walnut Shaded Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Rosa Mae Green**

15. Birthplace **Bronson Mich**
(City, town, or county) (State or foreign country)

16. (a) Informant **William Weatherman**

(b) Address **806 S. Nettleton**

17. (a) **Burial** (b) Date thereof **Sept 1 - 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple South Elm**

18. (a) Signature of funeral director **Alma Schmeiger**

(b) Address **Springfield Mo**

19. (a) **Aug 31, 1940** (b) **W E Handley MD**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**
(c) City or town **Springfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **806 S. Nettleton**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **25**,
year **1940** hour **11:15** minute **A** M.

21. I hereby certify that I attended the deceased **Aug 23-40**
Aug 25, 19**40**
that I last saw him alive on **Aug 25**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Asphyxiation**
Due to **Cancer of thyroid gland - primary**
Due to _____
Other conditions (Include pregnancy within 3 months of death) **50**

Major findings: Of operations _____
Of anatomic **Large Malignant gland cross-section + pressure on trachea**

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

23. Signature **W E Handley** (M. D. or other) _____
Address **432 W. 4th St** Date signed **8/25/40**

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

MOTHER FATHER

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

disposition

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 Harlow Knobb
Licensed Embalmer No. 4065
P. O. Address Springfield 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.