

Registration District No. 720

Primary Registration District No. 5951

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Putnam
(b) City or town Rural Liberty
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Livonia RFD 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether
In this community life
years, months or days) 1.2

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Putnam
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Livonia Mo RFD
(If rural, give location)
(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME Ernest Albert Roop

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 W

6. (b) Name of husband or wife Mary M Roop 6. (c) Age of husband or wife if alive 17 years

7. Birth date of deceased MAY 17 1868
(Month) (Day) (Year)

8. AGE: Years 72 Months 2 Days 3 If less than one day hr. min.

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

10. Usual occupation FARMER

11. Industry or business 9

MOTHER FATHER { 12. Name Unknown 9

18. Birthplace — (City, town, or county) (State or foreign country)

14. Maiden name Mary Roop 9

16. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant James Carter

(b) Address Wessonville Mo

17. (a) Burial (b) Date thereof July 21-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Concord Church

18. (a) Signature of funeral director F. D. Spustel

(b) Address Unionville Mo

19. (a) Aug 26 (b) E. E. McCallan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1940 hour 47 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 1 1940 to July 20 1940
that I last saw him alive on July 19 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to —
Due to —

Other conditions Nephritis Chronic
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations —
Of autopsy —
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 J. P. Hart (M. D. or other) —

Address Wessonville Mo Date signed Aug 20

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

RECEIVED

District Health Officer No. 10

District File Number 9-10-1710

Date Filed SEP 3 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 Marcel E. Husted
Licensed Embalmer No. 3307
P. O. Address Winnfield, Va.

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.