

No. 2  
3-20  
17-20

FILED NOV 15 1940 34927  
State File No. 20

Registration District No. 92 Primary Registration District No. 4055 Registrar's No. 15

1. PLACE OF DEATH:

(a) County Caldwell

(b) City or town Braymer  
(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 20  
(Specify whether)

In this community 20  
years, months or days

3. (a) PRINT FULL NAME Robert Lee Ross

3. (b) If veteran, name war no

3. (c) Social Security No. 40

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife --

6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased Oct. 25th 1940  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>X</u>	<u>X</u>	<u>12</u>	hr. <u>0</u> min. <u>0</u>

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

10. Usual occupation Child

11. Industry or business 0

12. Name Edward Ross

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

14. Maiden name Edna Clark

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

16. (a) Informant Edward Ross

(b) Address Braymer, Mo

17. (a) ~~BY EXEMPTION~~ Burial (b) Date thereof Nov. 6th, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Evergreen

18. (a) Signature of funeral director Bernard T. Mead

(b) Address Braymer, Mo

19. (a) Nov. 6, 40 (b) H. H. Patterson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Caldwell

(c) City or town Braymer  
(If outside city or town limits, write "RURAL")

(d) Street No. 0  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 5th  
year 1940 hour 9 minute a.m.

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

Immediate cause of death Septicemia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(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?  
at

(Specify type of place) \_\_\_\_\_  
While at work? (e) Means of injury 3

23. Signature John R. Crank (M.D. or other) D.O.

Address Braymer, Mo Date signed 11-6-40

Duration  
11-7-40

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3/6

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**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 Bernard L. Mead

Licensed Embalmer No. 2801

P. O. Address Praymer, 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **34987**  
Registrar's No. **15-**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **93**

Primary Registration District No. **4055-**

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

1. PLACE OF DEATH:  
(a) County **Caldwell**  
(b) City or town **Braymer**  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME **Robert Lee Rose**  
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 **s**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

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

8. AGE: Years Months Days If less than one day  
**12** 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)  
14. Maiden name (City, town, or county) (State or foreign country)  
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) (Date received local registrar) (b) (Registrar's signature)

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

20. DATE OF DEATH: Month **11** day **5-**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemia**  
Due to **abrasions on skin on infant's neck and subsequent infection of abrasions**  
Other conditions **M. M. B.**  
(Include pregnancy within 3 months of death)

Major findings: Of operations **26**  
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? \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_  
While at work? (e) Means of injury \_\_\_\_\_

23. Signature **John R. Crank** (M. D. or other) **DO**  
Address **Braymer, Mo** Date signed **12-1-40**

SUPPLEMENTAL

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

