DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35460

Registration District No. 384 Primary Registration District No. 4227 Registrar's No.

1. PLACE OF DEATH:
(a) County: Howell
(b) City or town: West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Cottage Hospital
(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 DEASCED:
(a) State: Missouri (b) County: Howell
(c) City or town: West Plains
(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.

3. (a) PRINT FULL NAME: Robert Kay Kreigh
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: male
5. Color or race: white
6. (a) Single, widowed, married, divorced:
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: October (Month) 25 (Day) 1940 (Year)
8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.
9. Birthplace: West Plains (City, town, or county) Missouri (State or foreign country)
10. Usual occupation:
11. Industry or business:
FATHER
12. Name: Percival Kreigh
13. Birthplace: Peterson (City, town, or county) Iowa (State or foreign country)
MOTHER
14. Maiden name: Julia K. Ray
15. Birthplace: Rockview (City, town, or county) N. Carolina (State or foreign country)
16. (a) Informant's own signature: Percival Kreigh
(b) Address: West Plains, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 27, 40 (Month) (Day) (Year)
(c) Place: burial or cremation: Oak Lawn West Plains
18. (a) Signature of funeral director: Lawrence Cook
(b) Address: West Plains, Mo.
19. (a) 10-27-40 (Date received local registrar) (b) Vida W. Simons (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27 year 1940 hour 3 minute 15 A.M.
21. I hereby certify that I attended the deceased from Oct. 26, 1940 to Oct 27, 1940 that I last saw him alive on Oct 27, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Respiratory Failure	
Due to: Congenital atelectasis of lungs.	
Due to:	
Other conditions (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):
(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: C. Rose Bohner (M. D. or other)
Address: West Plains, Mo Date signed 10-28-40

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Officer No. 5,
District File Number 1046 1098
Date Filed

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 comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.