

13-40
7-39
X2315

APR 10 1941
1941
Registration District No. _____

Primary Registration District No. 5440

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

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:
Medical Center for Federal Prisoners, 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 Months 7 Days
(Specify whether years, months or days)
 In this community 3 Months 7 Days.

2. USUAL RESIDENCE OF DECEASED:
 Parish XXIX Rapides
 (a) State Louisiana (b) County XXIX Rapides
 (c) City or town Alexandra
(If outside city or town limits, write "RURAL")
 (d) Street No. Unknown
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME CAREY, Robert J.
 (b) If veteran, name war Unknown
 (c) Social Security No. Unknown

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 8
 year 1941 hour 8 minute 12 A.M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Divorced
 (b) Name of husband or wife Theresa Schour
 (c) Age of husband or wife if alive Unknown years
 7. Birth date of deceased May 17, 1891
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from December 1, 1940 to March 8, 1941; that I last saw him alive on March 8, 1941 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>49</u>	<u>9</u>	<u>21</u>	hr. _____ min. _____

Immediate cause of death Heart Desesse, Pulvular Aortic.

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

Due to Syphilis Tertiary, Aneurysm Aorta.

10. Usual occupation Bookkeeper.

Due to _____

11. Industry or business _____

Other conditions _____
(Include pregnancy within 3 months of death)

12. Name Thomas J. Carey.
 13. Birthplace Union Louisiana
(City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy No autopsy

14. Maiden name Mary Eleanor McQuire
 15. Birthplace New Orleans, Louisiana.
(City, town, or county) (State or foreign country)

16. (a) Informant Deceased.
 (b) Address _____

22. If death was due to external causes, all in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

17. (a) Removal (b) Date thereof 3-8-41
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation New Orleans, La.

(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? _____

18. (a) Signature of funeral director Alvin Johnson
 (b) Address Springfield, Mo.
(Specify type of place) (City or town) (County) (State)

23. Signature _____ (M. D. or other) _____
 Address Clinical Director, Springfield, Missouri.
 Date signed 3-8-41

19. (a) 3-8-41 (b) W. E. Handley, M.D.
(Date received local registrar) (Registrar's signature)

39
0
0

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

X

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

Wayne Hinkle

Licensed Embalmer No. *3444*

P. O. Address *Springfield*

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.