

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34945**
Registrar's No. **807**

FILED NOV 11 1941

Registration District No. _____

Primary Registration District No. **2001**

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

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(c) Name of hospital or institution: **1977 Grace**
(d) Length of stay: **Lifetime**
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**
(c) City or town **Springfield**
(d) Street No. **1977 Grace**
(e) Citizen of foreign country? **No**
If yes, name country _____

3. (a) PRINT FULL NAME

Bobby Joe Erwin

(b) If veteran, name war **No**

(c) Social Security No. **None**

4. Sex **M**

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 **Feb 25 1941**

8. AGE:

Years **10** Months **7** Days **12**
If less than one day _____ hr. _____ min.

9. Birthplace **Springfield Mo**

10. Usual occupation **Child**

11. Industry or business _____

12. Name **Omar Erwin**

13. Birthplace **Brighton MO**

14. Maiden name **Goldie Johnson**

15. Birthplace **Brighton MO**

16. (a) Informant **Omar Erwin**

(b) Address **1977 Grace Springfield MO**

17. (a) **Burial** (b) Date thereof **10-8-41**

(c) Place: burial or cremation **Brighton MO**

18. (a) Signature of funeral director **Dunn Funeral Home**

(b) Address **Springfield MO**

19. (a) **10-8-41** (b) **W.E. Handley MD**

984 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **7**
year **1941** hour **7:30** minute **AM**

21. I hereby certify that I attended the deceased from **2-25-41** 19 to **10-7-41** 19;
that I last saw him alive on **6-28-41** 19;
and that death occurred on the date and hour stated above.

Immediate cause of death **Hydrocephalus + Spina bifida** **Congenital**

Due to _____
Due to _____

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

Major findings: Of operations _____

Of autopsy _____

Duration

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? _____

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

23. Signature **Paul J. Schwartz** (M. D. or other) _____
address **Springfield, Mo.** Date signed **10-7-41**

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 Lawrence L. Hall
Licensed Embalmer No. 2784
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, fact should be so stated above.

X