

Registration District No. 411

Primary Registration District No. 2002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Gasper
(b) City or town Superior
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 617 N. Byers
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 25 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Gasper
(c) City or town Superior (If outside city or town limits, write "RURAL")
(d) Street No. 617 N. Byers (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert McCallen McCammon Jr.

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 Married
6. (b) Name of husband or wife Nellie 6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased April 30 1883 (Month) (Day) (Year)

8. AGE: Years 58 Months 7 Days 23 If less than one day hr. _____ min. _____

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

10. Usual occupation Watchmaker & Timekeeper

11. Industry or business _____

12. Name Robert M. McCammon Jr.

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

14. Maiden name Sarah Fitzgerald (City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Nellie McCammon
(b) Address 617 N. Byers

17. (a) Burial (b) Date thereof 12-24-1941 (Burial, cremation, etc.) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope Cemetery

18. (a) Signature of funeral director Thurston Dillon
(b) Address 4th & Wall

19. (a) 12-20-41 (b) Ed S. James (Date received for registrar) (Registrar's signature)

MEDICAL CERTIFICATION

10. DATE OF DEATH, Month Dec day 23 year 1941 hour 8 minute 20 a.m.

21. I hereby certify that I attended the deceased from Dec. 18 1941 to Dec. 23 1941
that I last saw him alive on Dec. 23 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration _____

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) 12/18

Major findings: Of operations _____

Of autopsy Same as above

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 W. R. Kinney (M. D. certifier)
Address Gasper, Mo. Date signed 12-23-41

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

44
2
5

42-1-1147

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.....

Don Titrick

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Don Titrick

Licensed Embalmer No. *4008*

P. O. Address *Joplin, 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.