

S. No. 1-13-1
5-1

FILED JAN 28 1942

Registration District No. 598

Primary Registration District No. 4355

State File No. _____

Registrar's No. 19

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

1. PLACE OF DEATH:
 (a) County Morgan
 (b) City or town Versailles
(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 _____
years, months or days

3. (a) PRINT FULL NAME Loren Olin Routen
 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 Single
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 27 1941
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 20 hr. min.

9. Birthplace Versailles Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____
 11. Industry or business _____

MOTHER FATHER { 12. Name Olin Routen
 13. Birthplace Missouri
(City, town, or county) (State or foreign country)
 14. Maiden name Addie Mae McFarland
 15. Birthplace Oklahoma
(City, town, or county) (State or foreign country)

16. (a) Informant Olin Routen
 (b) Address Versailles, Missouri
 17. (a) Burial (b) Date thereof 6-18-1941
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Big Rock

18. (a) Signature of funeral director Phillips Funeral Home
 (b) Address Eidon, Missouri
 19. (a) 6-17-1941 (b) Wall F. Berry
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Morgan
 (c) City or town Versailles
(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.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 17
 year 1941 hour 10 minute 10 A. M.

21. I hereby certify that I attended the deceased from June 11, 1941 to June 17, 1941, that I last saw him alive on June 17, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
 Duration 5 days

Due to _____
 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? _____ (c) Means of injury _____
 23. Signature J. L. Washburn (M. D. or other) J. M. S.
 Address Versailles, Mo Date signed 6/17/41

RECEIVED

District Health Officer No. 7,

District File Number 12-41-2202

Date Filed 1-15-42

STATEMENT BY LICENSED EMBALMER

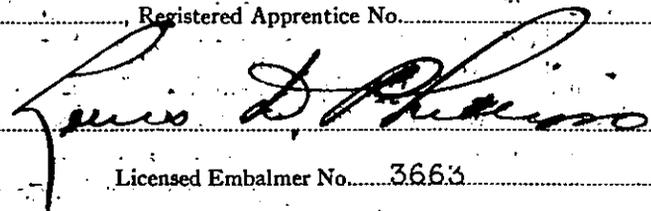
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Louis D. Phillips

Registered Apprentice No.

working under my personal supervision.

Signed



Licensed Embalmer No. 3663

P. O. Address Eldon

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.

Registration District No. 598

Primary Registration District No. 4355

Registrar's No.

1. PLACE OF DEATH:
 (a) County Morgan
 (b) City or town Marsailles
 (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..... years, months or days)

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) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Loren O Ruten
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 19 year 1941 hour..... minute..... M.
 21. I hereby certify that I attended the deceased from..... 19.....
 that I last saw him..... alive on..... 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

4. Sex M 5. Color or race W 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 May 27 1941
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.
- - 19 11 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.....
 15. Birthplace..... (City, town, or county) (State or foreign country)

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

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)
 (Burial, cremation, or removal)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

Duration
 Immediate cause of death.....

Due to Broncho pneumonia
Whooping cough 1WK
 Due to.....

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

Major findings:
 Of operations..... 9
 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?

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

23. Signature L. Harkness (M. D. or other) MD
 Address Marsailles Mo Date signed 7/3/41

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

SUPPLEMENTARY

