

5-42
5-17-39
X32873

FILED DEC 8 1942
Registration District No. 87

Primary Registration District No. 5319

State File No. _____
Registrar's No. 38

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town So. of Otterville Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
One mile South of Otterville
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Douglas ⁹⁹⁹

(c) City or town Lawerance
(If outside city or town limits, write "RURAL")

(d) Street No. 701 Elm Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Robert R. Church

3. (b) If veteran, name war No

3. (c) Social Security No. 513-12-0558

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11th.
year 1942 hour 1.00 minute 15 M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ Never Seen Alive _____
and that death occurred on the date and hour stated above.

4. Sex Male White Single
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 October 31, 1923
(Month) (Day) (Year)

Immediate cause of death Carbon Monoxide Poison.
Duration ?

8. AGE: Years Months Days If less than one day
19 0 11 _____ hr. _____ min.

Due to _____

Due to _____

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

9. Birthplace Junction City, Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Roofer

Major findings:
Of operations _____

Of autopsy No

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

11. Industry or business _____

MOTHER FATHER { 12. Name Fred Church

{ 13. Birthplace Junction City, Kansas
(City, town, or county) (State or foreign country)

{ 14. Maiden name Dorothy Dickerman

{ 15. Birthplace Perry Okla.
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. C. B. Rumsey

(b) Address Lawerance, Kansas

17. (a) Burial (b) Date thereof Nov. 13/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawerance Kansas

18. (a) Signature of funeral director L. J. Meister

(b) Address Boonville, Missouri

19. (a) Nov - 16 - 1942 (b) Miss W. W. Robison
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident ⁰²⁷

(b) Date of occurrence November 11, 1942

(c) Where did injury occur? Otterville Cooper Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on County public road
(Specify type of place)

While at work? No (c) Means of injury th

23. Signature L. J. Meister th (M. D. or other)
Address Boonville Mo. Date signed 11-11-42

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 12-7-42

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 _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed L. T. Filander

Licensed Embalmer No. 1399

P. O. Address Highway 100

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36964
Registrar's No. 38

Registration District No. 84

Primary Registration District No. 5319

1. PLACE OF DEATH:

(a) County Cooper
(b) City or town Rural
(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 Robert R Church

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 _____ S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 3
(Month) (Day) (Year)

8. AGE: Years 19 Months _____ Days _____ If less than one day _____ min.

9. Birthplace: _____
(City, town, or county) (State or foreign country) Kansas

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1942 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 Carbon monoxide poison Duration _____

Due to Broken exhaust pipe on car. Body found in front seat of car.

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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)

(b) 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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

17813
14

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-36964