

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 5 1942

Registration District No. 128

Primary Registration District No. 2000

Registrar's No.

1. PLACE OF DEATH: **Greene:**
 (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: **St. John Hosp.**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: **2 Days**
6 Months (Specify whether years, months or days)
 In this community: _____

2. USUAL RESIDENCE OF DECEASED: **39**
 (a) State: **Missouri** (b) County: **Greene**
 (c) City or town: **Springfield**
 (If outside city or town limits, write "RURAL")
 (d) Street No.: **1857 N. Lyon**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country: _____

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME: **Arthur W. Rasback**
 3. (b) If veteran, name war: **no**
 3. (c) Social Security No.: **Unknown**

20. DATE OF DEATH: Month **Nov.** day **18**
 year **1942** hour **6** minute **5 a. m.**

4. Sex: **Male**
 5. Color or race: **White**
 6. (a) Single, widowed, married, divorced: **3 Divorced**
 6. (b) Name of husband or wife: **Unknown**
 6. (c) Age of husband or wife if alive: **Unknown** years
 7. Birth date of deceased: **July 1 1890**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Jan 16 1942** to **11-18 1942**
 that I last saw him alive on **11-17 1942**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic Nephritis**
 Duration: **6 Mos.**

8. AGE: Years **52 2** Months **4** Days **17**
 If less than one day hr. min.

Due to _____
 Due to _____

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

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

10. Usual occupation: **M.K.T. Railroad**

Major findings: **131 f**
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business: **John M. Rasback**
 12. Name: **John M. Rasback**
 13. Birthplace: **Clinton Illinois**
 (City, town, or county) (State or foreign country)
 14. Maiden name: **Harriett Steiner**
 15. Birthplace: **Wichita Kansas**
 (City, town, or county) (State or foreign country)

16. (a) Informant: **Angelyn Rasback**
 (b) Address: **Springfield, Mo.**

17. (a) **Burial** (b) Date thereof: **Nov. 20, 1942**
 (Method, cremation, or removal) (Month) (Day) (Year)
 (c) Place: **Parsons, Kansas**

18. (a) Signature of funeral director: **H.H. Lohmeyer**
 (b) Address: **Springfield, Mo.**

19. (a) **11-20-42** (b) **H. W. Handley**
 (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) _____
 (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? _____

23. Signature: **Max Schup** (M. D. or other) **MD**
 Address: **Springfield, Mo.** Date signed **11-7-42**

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

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. Sohier Gorman*

Licensed Embalmer No. *2177*

P. O. Address *Springfield ma*

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.