

REG. MAR 13 1945
Registration District No. _____

Primary Registration District No. 5579

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Marion
(c) Name of hospital or institution: Jasper Co. TB Hospital
(d) Length of stay: In hospital or institution 54 days

In this community _____ years, months or days

3. (a) PRINT FULL NAME Robert T. Doy

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex M 5. Color or Race Wh 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 18 1881
(Month) (Day) (Year)

8. AGE: Years 62 Months 0 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Bridge Builder

11. Industry or business _____

12. Name John Doy

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

14. Maiden name Quanda Long

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

16. (a) Informant's own signature Robert

(b) Address _____

17. (a) Burial (b) Date thereof Feb 14 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jasper Mo

18. (a) Signature of funeral director Walt City Ltd Co
(b) Address Walt City, Mo

19. (a) Feb 11 1943 (b) Mrs. Dillidaga
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison
(c) City or town Parkia
(d) Street No. _____
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 11
year 1943 hour 11 minute 15 a M.

21. I hereby certify that I attended the deceased from Feb 9, 1943 to Feb 11, 1943; that I last saw him alive on Feb 11, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to _____
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? _____
(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 J. E. Douglas (M. D. or other)
Address Walt City Date signed 2/11/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REV. 5-17-39 I 19351

43-2-185

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 *A. K. Mills*.....

Licensed Embalmer No. 347.....

P. O. Address *North City 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, above space should be left blank.