DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 12 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24235

Registration District No. 6 Primary Registration District No. 5031 Registrar's No. 22

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

1. PLACE OF DEATH:
(a) County AUDRAIN
(b) City or town RURAL (WIVRE twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 10 Mi South of VANDALIA
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 23 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Audrain
(c) City or town Rural (WIVRE twp
(If outside city or town limits, write "RURAL")
(d) Street No. 10 Mi So Vandalia
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ROBERT RAY DANIELS
3. (b) If veteran, name war WORLD WAR II
3. (c) Social Security No. NONE

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 (Month) 9 (Day) 1920 (Year)

8. AGE: Years 23 Months 2 Days 17 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) ..... (State or foreign country)
10. Usual occupation FARMING
11. Industry or business .....
FATHER
12. Name MARCELLUS M. DANIELS
13. Birthplace BYLIS, IL (City, town, or county) ILLINOIS (State or foreign country)
MOTHER
14. Maiden name GRACE WEATHERAL
15. Birthplace UNKNOWN (City, town, or county) INDIANA (State or foreign country)
16. (a) Informant Mrs. M. Daniels
(b) Address Vandalia, Mo.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 30 1943 (Month) (Day) (Year)
(c) Place: burial or cremation VANDALIA CEMETERY
18. (a) Signature of funeral director W. S. Waters
(b) Address Vandalia
19. (a) July 29 1943 (Date received local registrar) (b) Mallie Fugua (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
year 1943 hour 2 minute 00 M.
21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...;
that I last saw h..... alive on ....., 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death Coroner's Verdict
I find the deceased came to his death by suicide by shooting him self in the right temple with a 410 shotgun
Due to
Due to 7/26/43 Ey Burton, Coroner
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

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

164C

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) suicide
(b) Date of occurrence 7/26/43
(c) Where did injury occur? (WIVRE twp Rural (City or town) Audrain (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on farm (Specify type of place)
While at work? no (e) Means of injury with gun
23. Signature Ey Burton, Coroner (M. D. or other)
Address Mexico, Mo Date signed 7/26/43

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(Licensed Embalmer's Statement on Reverse Side)

DEC 3 1943

RECEIVED
District Health Officer No. 10
District File Number 8-43-1351
Date Filed AUG 11 1943

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 N. S. Thatcher

Licensed Embalmer No. 4298

P. O. Address Vandalia Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24235

Registration District No. ____ Primary Registration District No. ____ Registrar's No. ____

1. PLACE OF DEATH:
(a) County: Gentrain
(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 years, months or days)
In this community: 23 yrs

2. USUAL RESIDENCE OF DEACESED:
(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. Daniels
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: May (Month) 9 (Day) 1922 (Year)
8. AGE: Years 23 | Months 2 | Days ____ | If less than one day: ____ hr. ____ min.
9. Birthplace: Gentrain (City, town, or county) Missouri (State or foreign country)
10. Usual occupation ____
11. Industry or business ____

FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)

MOTHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) ____ (State or foreign country)

16. (a) Informant ____
(b) Address ____
17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____
18. (a) Signature of funeral director ____
(b) Address ____
19. (a) Oct. 4 1943 (Date received local registrar) (b) Mallie Fugua (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 26 year 1943 hour ____ minute ____ M.
21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__; that I last saw h__ alive on ____, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
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? ____ (e) Means of injury ____

23. Signature ____ (M. D. or other) ____
Address ____ Date signed ____

SUPPLEMENTARY 26

DEC 3 1964

S-24235