

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

29443
Do not use this space.

FILED SEP 13 1943

1. PLACE OF DEATH

(a) County Saline Registration District No. 795
 (b) Township Marshall Primary Registration District No. 6039
 (c) City..... (d) Street No. 2 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 5 yrs. 10 mos. 3 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Roberta Louise Breen

(a) Residence, No. Kansas City, Missouri St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) September 4, 1932
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
10 11 17

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year).....
 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) Lexington (STATE OR COUNTRY) Missouri

FATHER
 13. NAME Dan Breen

14. BIRTHPLACE (CITY OR TOWN) Adaire County (STATE OR COUNTRY) Missouri

MOTHER
 15. MAIDEN NAME Mary E. Menaugh

16. BIRTHPLACE (CITY OR TOWN) Lexington (STATE OR COUNTRY) Missouri

17. INFORMANT Records Missouri State School (ADDRESS) Marshall mo

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Lexington mo DATE aug - 23 '43

19. FUNERAL DIRECTOR (NAME) Harry Hersberger (ADDRESS) Marshall mo

20. FILED 8/23 '43 W. O. Westbrook Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 21 1943

22. I HEREBY CERTIFY, That I attended deceased from August 15, 1943, to August 21, 1943
 I last saw her alive on August 21, 1943 Death is said to have occurred on the date stated above, at 12.30 A M
 The principal cause of death and related causes of importance were as follows:

Pneumonia Date of onset 8-19-43

Other contributory causes of importance:
Low grade idiot with epilepsy

Name of operation..... Date of.....
 What test confirmed diagnosis? Examination Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify.....
 (Signed) Oliver Eugene Bowditch, M. D.
 (Address) Missouri State School
Marshall, Missouri

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 9-10-43

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 Harry Heushiba

Registered Apprentice No. 334, working under my personal supervision.

Signed Fred Wilkerson

Licensed Embalmer No. 2478

P. O. Address Clenton

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

- (a) County Saline
 (b) City or town Marshall
 (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 Roberta Louisa Preen

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex
- F
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
- Sept 4, 1932
-
- (Month) (Day) (Year)

8. AGE: Years
- 10
- Months
- 10
- Days
- 10
- If less than one day, min.

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

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) (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) (Date received local registrar) (b) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- Aug
- day
- 13
- year
- 43
- hour
- 12
- minute
- 50
- M.

21. I hereby certify that I attended the deceased from..... 19.....
-
- that I last saw him/her alive on..... 19.....
-
- and that death occurred on the date and hour stated above.
-
- Immediate cause of death.....

Duration

Due to Bronchial - vascularDue to child Blau Pinner Bronchial kid

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?

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

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

VED FOR

24mo:

29443