

S. No. 2
M-5-42
v. 5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30905

FILED OCT 13 1944

State File No.

Registration District No. 128

Primary Registration District No. 5465

Registrar's No. 785

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Rural, N. Campbell Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Route 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Rural, Springfield, - N. Campbell Twp.
(If outside city or town limits, write "RURAL")
(d) Street No. Route 4
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Roscoe Harold Gharst
3. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs. Anna Gharst 6. (c) Age of husband or wife if alive Unknown years
7. Birth date of deceased May 13, 1883
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month September day 26th,
year 1944 hour 10:40 minute _____ P. M.
21. I hereby certify that I attended the deceased from 11/9/44
_____ 19____ to 9/20 _____ 19____

8. AGE: Years 61 Months 4 Days 13 If less than one day
hr. _____ min. _____

that I last saw him alive on 9/20 _____ 19____
and that death occurred on the date and hour stated above
Immediate cause of death Cancer of throat Duration _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

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

10. Usual occupation Manager

11. Industry or business Truck Lines

MOTHER FATHER
12. Name UNK.
13. Birthplace UNK. UNK.
(City, town, or county) (State or foreign country)
14. Maiden name UNK.
15. Birthplace UNK. UNK.
(City, town, or county) (State or foreign country)

Major findings: Biopsy for diagnosis PHYSICIAN _____
Of operations _____ Underline the cause to which death should be charged statistically.
Of autopsy none

16. (a) Informant Mrs. Anna Gharst

(b) Address Springfield, Missouri

17. (a) Removal (b) Date thereof Sept. 29, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Missouri

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?

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 9-29-44 (b) Dr. W. E. Handley
(Date received local registrar) (Registrar's signature)

While at work? Italy (Specify type of place) (c) Means of injury _____
23. Signature Italy (M. D. or other) _____
Address Spfld, Mo. Date signed _____

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

700

39
Twp

458

JUL 28 1947

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 *Harlow Knabb*.....

Licensed Embalmer No. *4065*.....

P. O. Address *Springfield, 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, fact should be so stated above.

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