

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 9 1944

Registration District No. _____

Primary Registration District No. 4468

Registrar's No. 43

1. PLACE OF DEATH:

- (a) County ST. GENEVIEVE
- (b) City or town ST. MARY'S
(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) 1

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (years, months or days)

3. (a) PRINT FULL NAME ROBERT JOSEPH WILLIS

3. (b) If veteran, name war _____ 3. (c) Social Security No. 497-01-3415

4. Sex MALE 5. Color or race COLORED 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MARY M. HANDLES 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased JUN 9 12 1898
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>2</u>	<u>2</u>	hr. _____ min. _____

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

10. Usual occupation COOK

11. Industry or business CAFE

12. Name JAMES WILLIS

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

14. Maiden name HARRIET ROPER

15. Birthplace PERRY CO MO
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. M. Willis

(b) Address St. Mary's Ins

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-44
(Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Ins

18. (a) Signature of funeral director Res. C. Basher

(b) Address St. Genevieve Ins

19. (a) Sept 16/44 (b) T.W. Douglas
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MISSOURI (b) County ST. GENEVIEVE
- (c) City or town ST MARY'S 95
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 14
year 1944 hour 5 minute 20 P. M.

21. I hereby certify that I attended the deceased from 5/7/42
1942 to 3/14/44 1944
that I last saw him alive on Sept. 13 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis 10 yrs
Duration

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN [Signature]
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 0

23. Signature Arthur E. [Signature] (M. D. or other) M.D.
Address 516. [Signature] Date signed 9-16-44

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

9500

RECEIVED

District Health Officer No. 4

District File Number 1044-438

Date Filed: 10-6-44

OCT 23 1944

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. C. Baker*

Licensed Embalmer No. 1981

P. O. Address *St. Genevieve 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.