

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 19 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 953

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Hannas
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
121 E mo. ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether)
In this community Do not know
years, months or days

3. (a) PRINT
FULL NAME

Robert Rouman

3. (b) If veteran,

name was Do not know

3. (c) Social Security

No. _____

4. Male 5. Color or White 6. (a) Single, widowed, married,
divorced 9
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 _____ hr. _____ min.

9. Birthplace Do not know 9
(City, town, or county) (State or foreign country)

10. Usual occupation Do

11. Industry or business Do

12. Name Not 9

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

14. Maiden name Know 9

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

16. (a) Informant Coroner office

(b) Address Hannas City mo

17. (a) Removal (b) Date thereof 2/28/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sweet Springs mo

18. (a) Signature of funeral director Pasanti's Bros.

(b) Address Hannas City mo

19. (a) 2-28-45 (b) N E Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Jackson
(c) City or town Hannas city mo
(If outside city or town limits, write "RURAL")
(d) Street No. 121 E mo. ave.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27
year 1945 hour 8 minute A 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 Coronary occlusion
Due to arterial sclerosis

Due to 94a
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations Histology & Immu
Of autopsy not
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)
(c) Means of injury _____
23. Signature James C. Baker M. D. or other
Address 1424 prof. pldy Date signed 2-28-45

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.....

Licensed Embalmer No.....

P. O. Address.....

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.