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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 9 1945

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

State File No. 9700

Registrar's No. 252

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital,
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield
(If outside city or town limits, write "RURAL")

(d) Street No. 505 Boonville
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Charles Roberson

3. (b) If veteran, name war UNK.

3. (c) Social Security No. UNK.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife UNK.

6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased UNK. (Month) UNK. (Day) 1873 (Year)

8. AGE: Years 72 | Months UNK. | Days UNK. | If less than one day hr. min.

9. Birthplace Bella Vista, Co: (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Unknown

11. Industry or business Unknown

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

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

16. (a) Informant City Hospital
(b) Address Springfield, Missouri.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation East Lawn

18. (a) Signature of funeral director Fred C. Phieme
(b) Address 1100 Boonville Ave., Spfd., Mo.

19. (a) 3-24-45 (Date received local registrar) (b) E. W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23 year 1945 hour 12 minute 45 P.M.

21. I hereby certify that I attended the deceased from 3/21, 1945 to 3/23, 1945 that I last saw him alive on 3/23, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Primary anemia	?
Due to	
Due to	
Other conditions Sinus Inversis (Include pregnancy within 3 months of death)	Congenital

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 W. Roland Langston (M. D. or other) MD
Address Springfield, Mo. Date signed 3/24/45

(Licensed Embalmer's Statement on Reverse Side)

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. 2899, working under my personal supervision.

Signed Fred C. Phieve

Licensed Embalmer No. 2899

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.