V. S. No. 2
50M—5-42
Rev. 5-17-39
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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. 9718

Registrar's No. 234

**1. PLACE OF DEATH:**

(a) County GREENE

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

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

(d) Length of stay: In hospital or institution 3 weeks (Specify whether
In this community years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Taney Co.

(c) City or town Ocie Rural 101
(If outside city or town limits, write "RURAL")

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

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

If yes, name country None

3. (a) PRINT FULL NAME Bobby Lee Taber

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased Oct. (Month) 11 (Day) 1940 (Year)

8. AGE: Years 4 Months 5 Days 7 If less than one day hr. min.

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

10. Usual occupation Child

11. Industry or business

FATHER
12. Name Edward Taber
13. Birthplace Ocie (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Freda Herd
15. Birthplace Green Co. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Edward Taber
(b) Address Ocie, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-45 (Month) (Day) (Year)
(c) Place: burial or cremation Rhodes Cemetery

18. (a) Signature of funeral director McClure Funeral Home
(b) Address Gainesville, Mo.

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 18 year 1945 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from 10-17-44, 19__, to 3-8-45, 19__; that I last saw him alive on 3-8, 1945 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Lymphatic leukemia | 5 mo |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

740

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 Lehan J. Bunch (M. D. or other)

Address Springfield Mo. Date signed 3-18-45

(Licensed Embalmer's Statement on Reverse Side)

APR 30 1945

## 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 Denver Roller

Licensed Embalmer No. 4006

P. O. Address Mtn. Home, Ark.

**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.**