No. 2
7-5-43
5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16949

FILED MAY 28 1945

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 399

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 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days (Specify whether years, months or days)

In this community 2 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Christian 21

(c) City or town Spokane Mo. 0
(If outside city or town limits, write "RURAL")

(d) Street No. None 0
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Jacob S. Rouk

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

3. (c) Social Security No. UNK.

4. Sex Male A

5. Color or race White

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

6. (b) Name of husband or wife Mrs L. E. Rouk

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased June (Month) 28 (Day) 1865 (Year)

8. AGE: Years 79 Months 10 Days 16 If less than one day ____ hr. ____ min.

9. Birthplace Unk (City, town, or county) Iowa (State or foreign country) 1

10. Usual occupation Merchant

11. Industry or business

FATHER
12. Name Frank Rouk
13. Birthplace Clark Knox (City, town, or county) (State or foreign country) 4

MOTHER
14. Maiden name Clark Knox
15. Birthplace Clark Knox (City, town, or county) (State or foreign country) 4

16. (a) Informant Mrs L. E. Rouk

(b) Address Springfield, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16 45 (Month) (Day) (Year)

(c) Place: burial or cremation Springfield Cemetery

18. (a) Signature of funeral director T. B. Chaffin

(b) Address Ozark Mo

19. (a) 5-16-45 (Date received local registrar) (b) by W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14th year 1945 hour 8 minute 10 a.m.

21. I hereby certify that I attended the deceased from 5-13-45, 19__, to 5-14-45, 19__; that I last saw him alive on 5-14-45, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	1 yr
Uremia	2 wks.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations — ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 H. P. Woodruff (M. D. or other)

Address Springfield, Mo Date signed 5-14-45

(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.....,

working under my personal supervision.

Signed T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark 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.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 899

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:
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Jacob S. Rank

3. (b) If veteran name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased June 2 1866
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 10 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 14 year 1945 hour minute 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 — Duration

Due to

Due to Arteriosclerotic nephritis

Other conditions
(Include pregnancy within 3 months of death)

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 Dr. P. Maddux (M. D. or other)
Address Springfield, Mo. Date signed 5-29-45

SUPPLEMENTARY

16949