V. S. No. 2
100M—5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

21572

State File No.

Registration District No. 260

Primary Registration District No. 6225

Registrar's No. 95

08
0
0

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

1. PLACE OF DEATH:

(a) County Vernon

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

(c) Name of hospital or institution: State Hospt. #3 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether

In this community same years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Green 104

(c) City or town Springfield 0 (If outside city or town limits, write "RURAL") 0

(d) Street No. 2049 N. National (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Edgar Marshall Robertson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M 0

5. Color or race W

6. (a) Single, widowed, married, divorced 9

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

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

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation unk

11. Industry or business

FATHER
12. Name Unk
13. Birthplace " (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name unk
15. Birthplace " (City, town, or county) 9 (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Nevada Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-26-45 (Month) (Day) (Year)

(c) Place: burial or cremation Springfield Mo.

18. (a) Signature of funeral director Klinger Fun. Home

(b) Address Springfield Mo.

19. (a) 6-28-45 (Date received local registrar) (b) Hazel B. Beurck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25th year 1945 hour 8 minute 20 P. M.

21. I hereby certify that I attended the deceased from June 22nd 1945 to June 25th 1945 that I last saw him alive on June 25th 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

930

Duration

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. R. Summers (M. D. or other)

Address Nevada Mo. Date signed 6-25-45

1331

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
Dispatch File Number 6-45-662
Date Filed 7-11-43

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 Mark Eichinger

Licensed Embalmer No. 2656

P. O. Address Nevada 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.