S. No. 2
1—1-4-41
5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 13 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24019

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 583

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: O'Reilly General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 1 day years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone 104
(c) City or town Marionville (Rural) 0
(If outside city or town limits, write "RURAL")
(d) Street No. Route #1 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - -

3. (a) PRINT FULL NAME ROBERT M. STEELE

3. (b) If veteran, name war WORLD WAR II

3. (c) Social Security No. 552-24-7126

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 July (Month) 13, (Day) 1923 (Year)

8. AGE: Years 22 Months 0 Days 14 If less than one day ..... hr. ..... min.

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

10. Usual occupation Miner

11. Industry or business Copper Mines

FATHER
12. Name Alfred S. Steele
13. Birthplace Stone County (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Grace A. Barton
15. Birthplace Crane (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Alfred S Steele
(b) Address Marionville R.1. Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof July 28, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Marionville, Missouri

18. (a) Signature of funeral director Alma Phillips Ferguson
(b) Address Springfield Mo

19. (a) 7-28-45 (Date received local registrar) (b) Dr W E Hartley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27 year 1945 hour 9 minute 10 A M.

21. I hereby certify that I attended the deceased from 26 July, 1945, to 27 July, 1945; that I last saw him alive on 27 July, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Contusion of brain, Generalized, severe.	1 day
Due to Automobile accident, 26 July 1945, at Billings, Missouri	
Due to	
Other conditions (include pregnancy within 3 months of death) Fracture, ribs, with perforation of lung, with secondary subcutaneous emphysema and bilateral pneumothorax.	
Major findings: Of operations No operation	
Of autopsy Confirmation of above diagnoses.	

PHYSICIAN
Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 26 July 1945
(c) Where did injury occur? Billings, Missouri (City or town) (County) 22 (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place --Highway #60 (Specify type of place)
While at work? No (e) Means of injury Auto accident

23. Signature [signature] Lt. Col., MC (M.D. or other)
Address O'ReillyGH, Springfield, Mo Date signed 7/27/45

(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.....

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.

S. No. 2B
5M—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. ..... AUG 13 1945

Registration District No. 126 Primary Registration District No. 2000 Registrar's No. 583

SUPPLEMENTARY

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 In this community ..... years, months or days)

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 Robert M. Steele

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 S

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

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

7. Birth date of deceased July (Month) 13 (Day) 1922 (Year)

8. AGE: Years 22 Months Days If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Mo (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 ..... day 27 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 Contusion of brain, generalized, severe. — Duration 1 day

Due to Automobile accident 26 July 1945 at Billings, Mo.

Due to Driver going to sleep at wheel. Car going off of road--overturning 3 times.

Other conditions Fracture ribs, with perforation of lung, with secondary subcutaneous emphysema, and bilateral pneumothorax.

Major findings: Of operations No operation

Of autopsy Confirmation of above diagnoses.

ADDITIONAL INFORMATION REQUESTED

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) Accident

(b) Date of occurrence 26 - July - 1945

(c) Where did injury occur? Billings Christian Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Highway #60 (Specify type of place)

While at work? No (e) Means of injury Automobile Accident

23. Signature Francis Murphy Lt Col. MC. M.D. or other

Address O'Reilly gen. Hosp. Date signed .....

24019