S. No. 2
M—5-43.
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I 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. 41473

FILED JAN 5 1946

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 125

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution: Jane Chenn Hospital O
(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 Missouri (b) County Jasper 49

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

(d) Street No. R#1 0
(If rural, give location)

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

If yes, name country ____

3. (a) PRINT FULL NAME Infant of Orland Gust

3. (b) If veteran, name war ✓

3. (c) Social Security No. —

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife ____

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

7. Birth date of deceased Dec (Month) 4 (Day) 1945 (Year)

8. AGE:

Years	Months	Days	If less than one day
X	X	X	6 hr. ____ min.

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

10. Usual occupation ____

11. Industry or business Child

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

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

16. (a) Informant Orland Gust
(b) Address R#1 Asbury

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7 (Month) (Day) 1945 (Year)
(c) Place: burial or cremation Crestline Cem.

18. (a) Signature of funeral director Webb City Und Co
(b) Address Webb City Mo.

19. (a) 12/7/45 (Date received local registrar) (b) P. L. Pritchett M.D. (Registrar's signature)

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MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Dec day 4
year 1945 hour 920 minute P. M.

21. I hereby certify that I attended the deceased from December Fourth, 19__ to Dec. 4, 1945
that I last saw her alive on Dec. 4, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Premature	6 3 4 Mos.
Due to	2 Ntw
Due to Premature labor	
Other conditions Premature separation of Placenta previa partialis of 1st twin.	6 hrs
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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. B. Marbaugh D.O. (M. D. or other)

Address 1701 Joplin St. Joplin Mo. Date signed 12-6-45

(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 myself,

....., Registered Apprentice No.....,

working under my personal supervision.

Signed: Clayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Webb City, 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.