

No. 2
5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27232

State File No. _____

Registrar's No. 3453

Registration District No. 147

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County JACKSON CITY MO.

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

(c) Name of hospital or institution:
OSTEOPATHIC HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos 14 days
In this community " 2 MONTHS 14 DAYS (Specify whether years, months or days)

3. (a) PRINT FULL NAME ROBERT LEE LUSTER

3. (b) If veteran, name war NO

*3. (c) Social Security No. NONE

4. Sex MALE 5. Color of race WHITE 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased. FEB 3 1936
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	10	6	7	_____ hr. _____ min.

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

10. Usual occupation STUDENT

11. Industry or business _____

12. Name HENRY S LUSTER

13. Birthplace COOPER CO. MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name NORA LEE BAUGHMAN
(City, town, or county) (State or foreign country)

15. Birthplace COOPER CO. MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. HENRY S LUSTER

(b) Address RED "2" CLARKSBURG MO.

17. (a) REMOVAL (b) Date thereof AUG. 11-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CLARKSBURG MISSOURI

18. (a) Signature of funeral director J. W. WAGNER
KANSAS CITY MO.

(b) Address _____

19. (a) 8-10-46 (b) Geraldine Holme
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County COOPER 27

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

(d) Street No. CLARKSBURG 0
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 1
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 10th
year 1946 hour 6: minute 10 P.M.

21. I hereby certify that I attended the deceased from 5/76 to Aug 10th 46
that I last saw him alive on Aug 10th and that death occurred on the date and hour stated above. 1946

Immediate cause of death Uremic poisoning Duration _____

Due to Chronic Glomerulonephritis

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: None 1315
Of operations _____

Of autopsy None
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? 2

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature C. Johnson (M. D. or other) MD

Address 976 E 11th Date signed Aug 10th 46

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

20073

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..... *Cecil R. Matthes*

..... Licensed Embalmer No. *3807*

..... P. O. Address..... *Kansas 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.