

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 26 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16534

State File No.

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **658**

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:
General Osteopathic Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 hrs 45 min.
(Specify whether lifetime)

In this community Lifetime
years, months or days

3. (a) PRINT FULL NAME. ROBERT EARL CHRISTIE

3. (b) If veteran, name war. None

3. (c) Social Security No. None

4. Sex. Male

5. Color or 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. May 9, 1947
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
0	0	0	14 hr. 45 min.

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

10. Usual occupation. no

11. Industry or business. _____

12. Name. Shirley Amos Christie

13. Birthplace. Armour, Missouri
(State or foreign country)

14. Maiden name. Betty Bonnett

15. Birthplace. Halls, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant. Shirley Christie (father)

(b) Address. R.F.D. # 6, St. Joseph, Mo.

17. (a) Burial. Burial (Date thereof) 5/11/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Sugar Creek Cemetery

18. (a) Signature of funeral director. John E. Smith

(b) Address. 6054 Pryor Ave., City

19. (a) 5-21-47. **(b) E. B. Jenkins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph, Rural
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. # 6
(Never lived outside of hospital) (If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10, year 1947 hour 4 minute 45 A.M.

21. I hereby certify that I attended the deceased from May 9, 1947 to May 10, 1947
that I last saw him alive on May 10, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Rutch

Due to _____

Due to _____

Other conditions 159
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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?) (c) Means of injury

23. Signature. Clifford L. Steedly (Physician or other) EE

Address 801 1/2 Prairie St Date signed 5/10/47

(Licensed Embalmer's Statement on Reverse Side)

St Joseph Mo

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

MOTHER FATHER

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.....

Roland D Clark, Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No. *3986*

P.O. Address *St Joseph 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.