

No. 2
1/47
17-39

National Office of Vital Statistics
FILED FEB 13 1948 318

1003

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution City Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay In hospital or institution 0
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill (b) County 999

(c) City or town Percy 11
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Bobby Preslar

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 0 years

7. Birth date of deceased 12 - 28 1947
(Month) (Day) (Year)

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

97 hr. 30 min.

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

11. Industry or business

12. Name James Preslar

13. Birthplace Ridgely, Tenn
(City, town, or county) (State or foreign country)

14. Maiden name Betty Preslar

15. Birthplace Dec 1
(City, town, or county) (State or foreign country)

16. (a) Informant James Preslar

(b) Address Percy, Ill

17. (a) Removal Removal (b) Date thereof 4-26-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Steelville, Ill

18. (a) Signature Rowland Mortuary Svc

(b) Address 4104 Manchester

19. (a) JAN 29 1948 (b) J. J. Bradshaw
(Date received local registrar) (Registrar's signature)

Jefferson City Printing Co.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25
year 1948 hour 3 minute 20 M.

21. I hereby certify that I attended the deceased from 11/11/48 to 11/11/48; that I last saw him alive on 11/11/48 and that death occurred on the date and hour stated above.

Immediate cause of death Congestive + Edema Bronchopneumonia + Edema of lung

Due to 11/11/48

Due to 11/11/48

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause of 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 115

23. Arthur E. Myler (M.D. or other) 11/11/48
Address 115 Date signed 11/11/48

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

288

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 Ronald O. Yahnske

Licensed Embalmer No. 3917

P. O. Address St. Louis

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 987

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Bobby Preslar
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 see 28
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. B. Preslar (Registrar's signature)
(Date received local registrar)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
Year 1948 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER, FATHER

FEB 26 1948

S-2973 - 1948