No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAR 4 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 6690 1807

Registrar's No.

1. PLACE OF DEATH:

(a) County

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

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

(d) Length of stay: In hospital or institution 18 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi 67

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

(d) Street No. R.R. #3 1
(If rural, give location) R.R

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

If yes, name country

3. (a) PRINT FULL NAME Robert CARROLL McCuiston

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 Married 1

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

6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased April (Month) 30 (Day) 1914 (Year)

8. AGE: Years	Months	Days	If less than one day
33	9	21	hr. min.

9. Birthplace Charleston (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Raymond McCustion
13. Birthplace Murray (City, town, or county) Kentucky 1 (State or foreign country)

MOTHER
14. Maiden name Gertrude Fox
15. Birthplace Charleston (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Norma McCustion
(b) Address Charleston, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-48 (Month) (Day) (Year)
(c) Place: burial or cremation Charleston, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4600 Washington Blvd.

19. (a) FEB 23 1948 (Date received local registrar) (b) J. T. Breneck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 21 year 1948 hour 1 minute 50 A.M.

21. I hereby certify that I attended the deceased from Feb 3, 1948 to Feb 21, 1948, that I last saw him alive on Feb 21, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure	Duration
Due to postoperative Lobectomy	1
Due to Bronchiectasis	1 mo 10
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

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 0

23. Signature J R Bradley (M. D. or other)

Address Barnes Hospital, Date signed 2/21/48

Jefferson City Printing Co.

(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 Henry M. Brammer

Licensed Embalmer No. 4200

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.