

S. No. 2
M-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

State File No. **29459**

FILED OCT 9 1948
128

Registration District No. _____ Primary Registration District No. **2000** Registrar's No. **832**

1. PLACE OF DEATH: **GREENE**
(a) County
(b) City or town **Springfield**
(c) Name of hospital or institution: **Springfield Baptist Hospital**
(d) Length of stay: In hospital or institution **2 days**
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Webster**
(c) City or town **Seymour**
(d) Street No. _____
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Robert ERB**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct** day **1** year **1948** hour **5** minute **05** P.M.
21. I hereby certify that I attended the deceased from **Sept 29** 19**48** to **Oct 1** 19**48**
that I last saw him alive on **Oct 1** 19**48**
and that death occurred on the date and hour stated above.

4. Sex **M** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Carrie Erb** 6. (c) Age of husband or wife if alive **51** years
7. Birth date of deceased **Dec 11 1984**
(Month) (Day) (Year)

Immediate cause of death **uremia**
Due to **Rheumatoid Arthritis**
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
63 **9** **20** hr. min.

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace **unknown Tenn**
(City, town, or county) (State or foreign country)
10. Usual occupation **Fruit Grower**

MOTHER FATHER
11. Industry or business _____
12. Name **Louis Erb**
13. Birthplace **unknown Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Annice Collins**
15. Birthplace **unknown Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Carrie Erb**
(b) Address **Seymour Mo**
17. (a) **Burial** (b) Date thereof **10 3 48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oak Lawn Cemetery**

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? _____

18. (a) Signature of funeral director **Kelly, Ferrell Bergman**
(b) Address **Seymour Mo**
19. (a) **10-7-48** (b) **W. Handley**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature **Gayd Caccaway** (M. D. or **MD**)
Address **Springfield Mo** Date signed **10/6/48**

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

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 H. H. Kelley
Licensed Embalmer No. 3334
P. O. Address. Fordland 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.