

FILED DEC 22 1948

Registration District No. **77**

Primary Registration District No. **5157**

Registrar's No. **309**

1. PLACE OF DEATH:

(a) County **CALLAWAY**

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

(c) Name of hospital or institution: **AUXVASSE TOWNSHIP** /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community **Life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **CALLAWAY**

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

(d) Street No. **AUXVASSE TOWNSHIP**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Robert L. ESTES**

(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **13**
year **1948** hour **3** minute **30 P.M.**

4. Sex **MALE** 5. Color or race **white**

6. (a) Single, widowed, married, divorced **MARRIED**

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

7. Birth date of deceased: **Dec.** (Month) **16** (Day) **1877** (Year)

21. I hereby certify that I attended the deceased from **6-10**, 19**48** to **12-13**, 19**48**
that I last saw him alive on **12-12**, 19**48**
and that death occurred on the date and hour stated above.

8. AGE: Years **71** Months **11** Days **27** If less than one day _____ hr. _____ min.

Immediate cause of death: **Cerebral Hemorrhage**
Cardio-Vascular hyperextension with arterial sclerosis

Due to _____

9. Birthplace **REFORM MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **FARMER**

Other conditions: **Cystitis & Prostate Hypertrophy**

Major findings: _____

Of operations: _____

Of autopsy: **937**

11. Industry or business _____

12. Name **WILLIAM ESTES**

13. Birthplace **CALLAWAY CO. MO**
(City, town, or county) (State or foreign country)

14. Maiden name **KARA CALLIKATT**

15. Birthplace **CALLAWAY CO. MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS R. L. ESTES**

(b) Address **STEEDMAN, MO**

17. (a) **BURIAL** (b) Date thereof **Dec. 16, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **REFORM MO**

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

18. (a) Signature of funeral director **Stan G. Maupin**

(b) Address **712 Court St. Fulton, MO**

19. (a) **Dec 15 1948** (b) **Joan Morosukhoff**
(Date received local registrar) (Registrar's signature)

23. Signature **W. O. Payne** (M. D. of county) _____
Address **Rt 6 Fulton** Date signed **12/14/48**

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

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RECEIVED
District Health Officer No. 9,
District File Number
Date Filed DEC 21 1948

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 Glen Y. Mauhin
Licensed Embalmer No. 2725
P. O. Address Fulton, 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.