

FILED DEC 29 1948

Registration District No. 387

Primary Registration District No. 5211

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Washington Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

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

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Robert Lee Decker

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 Ethel May Decker

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased 12 13 1890
(Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name James Decker

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

14. Maiden name Nancy Likes

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

16. (a) Informant Mrs Lee Decker

(b) Address _____

17. (a) Burial (b) Date thereof 12-19-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Emon

18. (a) Signature of funeral director E. A. Jackson

(b) Address Bozard Mo

19. (a) 12-17-48 (b) Mrs Rex Henderson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

(c) City or town Carroll Co (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 12 day 14 year 1948 hour 9 minute P.M.

21. I hereby certify that I attended the deceased from 12-14-48 19____ to 12-14-48 19____

that I last saw him alive on 12-14-48 and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy

Duration

sudden

Due to Hypertension

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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? _____

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

Signature B. C. Cole (M. D. or other) _____

Address Norfolk Mo Date signed 12-15-48

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 12-28-48.....

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 E. A. Dukerose

Licensed Embalmer No. 2534

P. O. Address Boyard 7th

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: