

No. 300
10.48

FILED JUL 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20747

BIRTH NO. _____ REG. DIST. NO. 166 PRIMARY REG. DIST. NO. 5604 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY Johnson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Johnson	
b. CITY OR TOWN Montserrat		c. CITY OR TOWN Montserrat	
c. LENGTH OF STAY (in this place) 70 Yr.		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____			

3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) Samuel c. (Last) Draper			4. DATE OF DEATH (Month) (Day) (Year) June 17 1950		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Dec. 31, 1875	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Montgomery Co. Missouri	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME William Draper		13b. MOTHER'S MAIDEN NAME Carolina Stewart		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS A.H. Draper Montserrat Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Self inflicted gun shot wound in head.			INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			= 976X	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none				

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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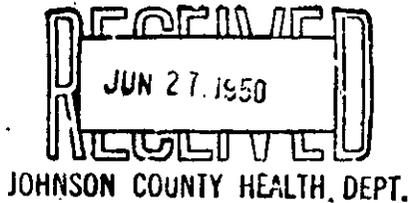
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) at home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Montserrat Johnson Mo	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 17 '50 3:00P		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Gun shot wound in head	

22. I hereby certify that I attended the deceased from **at death only 16/17/50**, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **3:00P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Kelly Rawlins M.D. Coronor Johnson Co Holden Mo 6/17/50		23b. ADDRESS _____		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 19, 1950		24c. NAME OF CEMETERY OR CREMATOR Sunset Hill	
				24d. LOCATION (City, town, or county) (State) Warrensburg, Missouri	

DATE REC'D BY LOCAL REG. June 19, 1950		REGISTRAR'S SIGNATURE Edna L. Beatty 1490		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sweeney-Phillips Warrensburg, Mo.	
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WRITE PLAINLY—USING 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.....

LEO P. McQUICK

Student Embalmer No. 358

working under my personal supervision.

Student Leo P. McQuick
Student Embalmer

Signed

J. Earl Priest
Licensed Embalmer No. 3878

P. O. Address Warrensburg, 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.