

FILED JAN 14 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Mosick  
State File No. 918

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY OR TOWN <u>SPRINGFIELD</u>		c. CITY OR TOWN <u>WALNUT GROVE 1390</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DAWSON HOME OF ELDERLY</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROBERT</u>		c. (Last) <u>MONDAY</u>	
b. (Middle) _____		4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 9, 1952</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 4 (unknown)</u>
9. AGE (In years) <u>49</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	11. BIRTHPLACE (State or foreign country) <u>DALLAS COUNTY, MO</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>S M MONDAY</u>	
13b. MOTHER'S MAIDEN NAME <u>(?) WILLIAMS</u>		14. NAME OF HUSBAND OR WIFE <u>X</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>LEUKETT MONDAY</u>		ADDRESS <u>SPRINGFIELD MO</u>	
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.			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia, lobar</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
ANTECEDENT CAUSES As forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Nephritis, Chronic</u> DUE TO (c) <u>Not known</u>			Not known
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<u>490x</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 2, 4, 1952</u> , to <u>Jan 9, 1952</u> , that I last saw the deceased alive on <u>Jan 1952</u> , and that death occurred at <u>12:15 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>To Mueich Mo</u>		23b. ADDRESS <u>Springfield, Missouri</u>	
23c. DATE SIGNED <u>1, 10, 52</u>		24a. BUREAU OF CREMATION REMOVAL (Specify) <u>Bureau</u>	
24b. DATE <u>1-11-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Brentwood Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>Walnut Grove, Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Brim - Daniel Ash Grove Mo</u>	
DATE REC'D BY LOCAL REG. <u>1-11-52</u>		REGISTRAR'S SIGNATURE <u>James H. Amos, M.D.</u>	

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Paul F. Sherry*

Licensed Embalmer No. *2427*

P. O. Address *Springfield*

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.