

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009043

STATE FILE NUMBER

FILED APR 6 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 325

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1628 E McDaniel</b>		d. STREET ADDRESS (If outside, give location) <b>1628 E. McDaniel</b>	
Length of stay in lb <b>1 year</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>ROBERT MICHAEL DE WALD</b>			4. DATE OF DEATH Month Day Year <b>March 26, 1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 30, 1903</b>	9. AGE (In years last birthday) <b>55</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Flight Instructor</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Air Force</b>	11. BIRTHPLACE (City and state or country) <b>Russell Co., Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John G. DeWald</b>	13b. MOTHER'S MAIDEN NAME <b>Katherine E. Lohmann</b>	14. NAME OF HUSBAND OR WIFE <b>-----</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Eva DeWald</b>	Address <b>Russell, Kansas</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot Wound in Head</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____		<b>976X</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? <b>1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>SHOT HIMSELF WITH 22 CAL. COLT AUTO. PISTOL. SHOT IN HEAD BEHIND RIGHT EAR</b>
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20c. TIME OF INJURY <b>Approx 10:00 p.m. March 26, 1959</b>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> AT WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. CITY, TOWN, OR LOCATION <b>Springfield, Greene, Missouri</b>	COUNTY <b>Greene</b>	STATE <b>Missouri</b>
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21. I attended the deceased from Death occurred <b>Approx 10:00 p.m.</b> to _____ and last saw her alive on _____ m on the date stated above; and to the best of my knowledge, from the causes stated.
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21a. SIGNATURE (Degree or title) <b>Ralph H. Crown</b>	21b. ADDRESS <b>Springfield, Missouri</b>	21c. DATE SIGNED <b>31 March 1959</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>March 30, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Russell Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Russell, Kansas</b>
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FUNERAL DIRECTOR <b>Jewell E. Windle</b>	ADDRESS <b>Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>4-1-59</b>	26. REGISTRAR'S SIGNATURE <b>Effie E. Melton</b>
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All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MAY 12 1959

DEC 1959

APR 7 1959

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 ..... Signature of Student Embalmer

Signed *Bernard F. Wright*

Licensed Embalmer No. *4293*  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.