

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

PLACE OF DEATH

Registration District No. 861
 Primary Registration District No. 6132
 File No. 26767-2
 Registered No. 10
 City Jamezville (No.) St. Ward

2. FULL NAME Robert Clarence Runner
 (a) Residence, No. St. Ward. (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male | **4. COLOR OR RACE** White | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nellie Jane Runner
6. DATE OF BIRTH (MONTH, DAY AND YEAR)
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 46

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Dale County
 (STATE OR COUNTRY)

10. NAME OF FATHER George Runner
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Eliza Walker
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Nellie Jane Runner
 (Address) Jamezville, Mo.

15. FILED 12/2 1929 [Signature]
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 6 1929
17. I HEREBY CERTIFY, That I attended deceased from
, 19....., to, 19.....
 that I last saw h..... alive on, 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
No. [Signature]
Chronic Heart Disease
31 (duration) yrs. mos. ds.
9-22

CONTRIBUTORY (SECONDARY) [Signature]
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) [Signature], M. D.
 19..... (Address) [Signature]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lone Pilgrims **DATE OF BURIAL** July 7 1929

20. UNDERTAKER [Signature] **ADDRESS** [Signature]

PLAINLY, WITH UNFADING INK. Information should be carefully supplied. All information should be in plain terms, so that it may be properly classified. Exact statements of occupation is very important.

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This man, Robert Clarence Rummer, suffered from "heart attacks", I am informed by his wife Mrs. Nellie Jane Rummer but there seems to be no knowledge of him having suffered from Tuberculosis of the lungs.

A handwritten signature in cursive script, appearing to read "R. C. Rummer". The signature is written in black ink and is positioned below the typed text.

Requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate:

Name: Robert Clarence Rummer

Who died at: Taney co on July 6, 1929

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: 900A

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Consumptive

Heart Lesion

Contributory: No Physician

Where was disease contracted? _____

Did operation precede death? _____ Date of _____

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Taney Registration District No. 861 File No. _____
 Township Swain Primary Registration District No. 6132 Registered No. 10
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Robert Clarence Cummer
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
44

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) _____ yrs. _____ mos. _____ ds.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT _____ (Address) _____

15. FILED 12/2, 1929 [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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17. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

. 19 (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER Had none ADDRESS _____

WRITING ONLY, WITH UNFADING INK--- THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGES should be stated EXACTLY. PRIVACY should be maintained. CAUSE OF DEATH, in plain terms, so that it may be properly classified.
 SMALL, NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY