

Registration District No. 395

Primary Registration District No. 4232

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Blue Springs  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) 2

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

In this community 25 yrs  
years, months or days

3. (a) PRINT FULL NAME Robert Worn Rumbaugh

(b) If veteran, name war none

(c) Social Security No. none

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_  
alive \_\_\_\_\_ years

7. Birth date of deceased Aug 31 1868  
(Month) (Day) (Year)

8. AGE: Years 71 Months 11 Days 21 If less than one day \_\_\_\_\_  
hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business Millworker

12. Name D. J. Rumbaugh

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

14. Maiden name Mary Daniels

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

16. (a) Informant Frank Rumbaugh

(b) Address Blue Springs Mo

17. (a) Buried (b) Date thereof 8-12-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation The Kinke. Idessa Mo

18. (a) Signature of funeral director R B Burt

(b) Address Blue Springs Mo

(a) Aug 26 1940 (b) Mrs Thomas Porter  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Blue Springs  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 10  
year 1940 hour 10:20 minute 9 M.

21. I hereby certify that I attended the deceased from October 26, 1939, to August 10, 1940,  
that I last saw him alive on July 27, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Asites Auricular Fibrillation  
(Include pregnancy within 3 months of death)  
Chronic Nephritis

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? 9/11 (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature E L Saunders (M. D. or other) MD

Address Independence Date signed Aug 11

Duration to not know

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**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.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**