

0. 2
13-40
7-39
X23189

STANDARD CERTIFICATE OF DEATH

State File No. 35654

Registration District No. 449

Primary Registration District No. 4467

Registrar's No. _____

1. PLACE OF DEATH:

(a) County LACLEDE
(b) City or town LEBANON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: WALLACE HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days)

3. (a) PRINT FULL NAME ROBERT WESLEY DARTON

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex M 5. Color or race Bl. 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife Andrew Darton 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased OCT 12 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 3 If less than one day _____ hr. _____ min.

9. Birthplace LEBANON MO
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name ANDREW W DARTON JR

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

14. Maiden name MARY CHAMBERS

15. Birthplace LEBANON MO
(City, town, or county) (State or foreign country)

16. (a) Informant A W Darton

(b) Address Lebanon Mo

17. (a) BURIAL (b) Date thereof OCT 16 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lebanon Mo

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON

19. (a) 10-16-40 (b) J. McCauley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE
(c) City or town LEBANON
(If outside city or town limits, write "RURAL")
(d) Street No. OLD TOWN
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT, day 15
year 1940 hour 12 minute 15 A. M.

21. I hereby certify that I attended the deceased from 10-12-40 to 10-15-40
that I last saw him alive on 10-15-40
and that death occurred on the date and hour stated above.

Immediate cause of death hematuria

Due to The infection

Due to _____

Other conditions (include pregnancy within 3 months of death) 11 154

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? Yes

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Lebanon Mo Date signed 10/15/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 7,
District File Number 11-40-1622
Date Filed 11-13-40

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 comply the above constitutes grounds for revocation of license.)

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