S. No. 2
M—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 21 1943

Registration District No. 7

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6840

State File No. 32199

Registrar's No. 28

1. PLACE OF DEATH:
(a) County Newton
(b) City or town Rural - Pierce City Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Van Buren Sub
HOME
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Newton
(c) City or town Rural Pierce City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) Citizen of foreign country? ~~Yes~~ No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME ROBERT STANLEY OZIAS

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M

5. Color or race White

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 (Month) 7 (Day) 43 (Year)

8. AGE: Years | Months | Days | If less than one day 1 hr. 5 min.

9. Birthplace Newton Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation infant

11. Industry or business .....

MOTHER FATHER

12. Name Stanley L Ozias

13. Birthplace Fullerton (City, town, or country) California (State or foreign country)

14. Maiden name Mary Catherine Cress

15. Birthplace Hearrington (City, town, or country) California (State or foreign country)

16. (a) Informant Mary Catherine Ozias
(b) Address Pierce City, Mo.

17. (a) 9/8/43 (Burial, cremation, or removal) (b) Date thereof 9-8-43 (Month) (Day) (Year)
(c) Place: burial or cremation Black Forest Cemetery

18. (a) Signature of funeral director Callaway
(b) Address Monett - Mo.

19. (a) Aug 8-43 (Date received local registrar) (b) Ruth Norwood (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 7 year 43 hour 10 minute 15 P.M.

21. I hereby certify that I attended the deceased from Aug 7 43, 19..., to Aug 7 - 19 42 that I last saw him alive on Aug 7 19 43 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Newborn - Term. Respiratory failure	1 hr
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 6 oz	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause to which death should be charged statistically.

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

23. Signature Frank New M.D. (M.D. or other)
Address Monett Mo Date signed 8/9/43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED 9-13-43

District Health Officer No.

District File Number ~~943-181~~ 943-181

Date Filed 9-13-43

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 J. P. Buchanan

Licensed Embalmer No. 3179

P. O. Address Sponett Mo.

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.