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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 18 1945

Registration District No. 170

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5625

State File No. Carlton 13761

Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE

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

(c) Name of hospital or institution: SLEEPER R.1.
(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 4 YRS

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County LACLEDE 53

(c) City or town RURAL 0
(If outside city or town limits, write "RURAL")

(d) Street No. R.1. SLEEPER
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ROBT. B. REAGAN

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife ALICE WILLIAMSON

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased JULY (Month) 25 (Day) 1860 (Year)

8. AGE: Years 84 Months 8 Days 4 If less than one day hr. min.

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

10. Usual occupation FARMER

11. Industry or business

MOTHER FATHER

12. Name ROBT. REAGAN

13. Birthplace NOT KNOWN (City, town, or county) (State or foreign country)

14. Maiden name NOT KNOWN

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

16. (a) Informant Alice Reagan

(b) Address R.1. Sleeper Mo

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-31-45 (Month) (Day) (Year)

(c) Place: burial or cremation MYETTA CEM.

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

(b) Address LEBANON MO.

19. (a) 4-3-45 (Date received local registrar) (b) Grace Roper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR day 29 year 1945 hour 10 minute A M.

21. I hereby certify that I attended the deceased from March 29th, 1945, to March 29, 1945, that I last saw him alive on March 29th, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis — Duration 8 hrs

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

C E Carlton

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 C E Carlton (M. D. or other)

Address Stoutland Mo Date signed 3-30-45

1070 (Licensed Embalmer's Statement on Reverse Side)

Received .....

Laclede County Health Unit

File No. 3-45-34

Date Filed 4/17/45

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 D D Palmer

Licensed Embalmer No. 1161

P. O. Address Lebanon 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.