

No. 2  
12-45  
17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27104

FILED AUG 20 1947

Registration District No. 77

Primary Registration District No. 3012

Registrar's No. 116

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

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution: Excelsior Springs Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 40 years (Specify whether years, months or days)

In this community 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay

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

(d) Street No. 418 E Broadway  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ROBERT B. CHRISTIAN

3. (b) If veteran, name war —

3. (c) Social Security No. —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24 year 1947 hour 6 A minute — M.

21. I hereby certify that I attended the deceased from July 17, 1947, to July 24, 1947.  
that I last saw him alive on July 23, 1947, and that death occurred on the date and hour stated above.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Jennie Christian

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased May 17, 1862  
(Month) (Day) (Year)

Immediate cause of death Heart Block

Duration 1 month

8. AGE: Years 85 Months 2 Days 7 If less than one day hr. min.

Due to Hypertension arteriosclerosis

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation Retired Theatre owner

PHYSICIAN

Major findings: Of operations —

Of autopsy —

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name Unknown

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

14. Maiden name Unknown

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

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? ( )

16. (a) Informant Mrs Jennie Christian

(b) Address Excelsior Springs Mo

23. Signature [Signature] (M. D. or other) MD

Address Excelsior Spg Mo Date signed 7/25/47

17. (a) B (b) Date thereof 7/25 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill Cemetery

18. (a) Signature of funeral director Clas O Hope

(b) Address Excelsior Springs Mo

19. (a) 7/30/47 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

*M. S. ...*

**RECEIVED**

**District Health Officer No. 8,**

District File Number \_\_\_\_\_

Date Filed 8-19-47

**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 James A. Moles

Licensed Embalmer No. 3296

P. O. Address Ex Springs Me

**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.**