

FILED NOV 15 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34191**

BIRTH NO. _____ REG. DIST. NO. **233** PRIMARY REG. DIST. NO. **H348** Registrar's No. **18**

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Montgomery	
b. CITY (If outside corporate limits, write RURAL and give town or township) Wellsville		c. CITY (If outside corporate limits, write RURAL and give township) Wellsville	
c. LENGTH OF STAY (in this place) 2 yr		d. STREET ADDRESS (If rural, give location) R. R. Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home			

3. NAME OF DECEASED a. (First) Robert b. (Middle) Lee c. (Last) Auchly			4. DATE OF DEATH (Month) (Day) (Year) November 6, 1950		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 28, 1872	9. AGE (In years last birthday) 77 IF UNDER 1 YEAR: Months 11 Days 8 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Montgomery City, Missouri	
10c. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Francis S. Auchly		13b. MOTHER'S MAIDEN NAME Mary Anna Hilbrand		14. NAME OF HUSBAND OR WIFE Edna M. Auchly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Robert B. Auchly ADDRESS Wellsville	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy		INTERVAL BETWEEN ONSET AND DEATH 3 day 10 year 334X
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Nov 4, 1950**, to **Nov 6, 1950**, that I last saw the deceased alive on **Nov 6, 1950**, and that death occurred at **1:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Willis H. Waller, M.D.		23b. ADDRESS Wellsville, Mo		23c. DATE SIGNED 11/6/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov. 8, 1950		24c. NAME OF CEMETERY OR CREMATORY City Cemetery	
24d. LOCATION (City, town, or county) Montgomery City, Mo.		24e. (State)			

DATE REC'D BY LOCAL REG. 11/9/50		REGISTRAR'S SIGNATURE W. S. Romann, Jr.		25. FEDERAL DIRECTOR'S SIGNATURE Schlanke Mortuary, Montgomery City, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

E. Boone Schlenker

Licensed Embalmer No. _____

4136

P. O. Address _____

Montgomery City

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.