

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

Rev. 5-17-30

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35853

State File No. _____

Registrar's No. 11

Registration District No. 210

Primary Registration District No. 5290

1. PLACE OF DEATH: 2

(a) County Clinton
(b) City or town Rural-Platt Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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 Allen Pickett 231

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bertha 6. (c) Age of husband or wife if _____

7. Birth date of deceased Nov - 23 - 1871
9 (Month) (Day) (Year)

8. AGE: Years 67 Months 10 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Joseph Pickett

13. Birthplace Clay County Mo. (City, town, or county) (State or foreign country)

14. Maiden name Mary Ann Warren

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

16. (a) Informant's own signature John P. Pickett

(b) Address Stewartville Mo.

17. (a) Stewartville (b) Date thereof Oct-5-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stewartville Mo.

18. (a) Signature of funeral director J. L. Gason

(b) Address Stewartville Mo.

19. (a) Oct-4-1939 (b) John M. Gason
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton

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

(d) Street No. Platt Township Clinton Co. (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 3
year 1939 hour 5 minute 55 P.M.

21. I hereby certify that I attended the deceased from Feb. 25
1939, to Oct 3, 1939;

that I last saw him alive on Oct 3, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration 3 months

Due to _____
Due to 946

Other conditions Cornary Thrombosis 9 months
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations none
Of autopsy none
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? _____

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

23. Signature J. M. Gason (M.D. or other) D.O.
Address Stewartville Date signed 10/4/39

Officer No. 114
NOV 14 1939

1139-1535

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 F. G. Lyons
Licensed Embalmer No. 952
P. O. Address Stewartville, Md.

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, above space should be left blank.