

FILED FEB

Registration District No. 604 Primary Registration District No. 4358 Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County New Madrid MO **1940**

(b) City or town New Madrid MO **2**

(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 \_\_\_\_\_ (Specify whether)

years, months or days 1 5 7

8. (a) PRINT FULL NAME GRACE ELIZABETH ROBINSON

3. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 1 1936 (Month) (Day) (Year)

8. AGE: Years 3 Months 6 Days 9 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Lake City Ark. (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name Jess Robinson 1

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

14. Maiden name Emma Scallap

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

16. (a) Informant Jess Robinson (b) Address Caton MO

17. (a) Interment (b) Date thereof Jan 15 1940 (c) Place: burial or cremation Maiden MO

18. (a) Signature of funeral director T. H. H. H. (b) Address New Madrid MO 523

19. (a) 1-27-40 (b) Wm O'Bannon (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County New Madrid

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13 year 1940 hour 10:00 minute 0 A. M.

21. I hereby certify that I attended the deceased from 1-13-40 to 1-13-40 that I last saw her alive on 1-13-40 and that death occurred on the date and hour stated above.

Immediate cause of death: Spinal meningitis (epidemic meningitis)

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

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

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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. H. H. H. (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**