

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.

SEP 12 1946
Registration District No. 12461

Primary Registration District No. 3024

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Lexington
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME Infant of Miss Flora E. Robinson
8. (b) If veteran, name war _____
8. (c) Social Security No. _____

4. Sex ma. 5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 19 - 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one day 1 hr. 30 min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name Flora Ruth Robinson
15. Birthplace Richmond Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Flora Ruth Robinson
(b) Address Richmond, Mo.

17. (a) Burial (b) Date thereof July 20 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington, Mo

18. (a) Signature of funeral director W. McKelley

(b) Address Lexington, Mo

19. (a) Sept 9-40 (b) Delia Bates
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Lafayette
(c) City or town Richmond
(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 July day 19
year 1940 hour 4 PM minute _____ M.

21. I hereby certify that I attended the deceased from birth
1940, 19. to death July 19, 1940
that I last saw him alive on July 19, 19.40
and that death occurred on the date and hour stated above.

Immediate cause of death Premature birth Duration _____
Due to miscarriage

Due to _____

Other conditions (Include pregnancy within 3 months of death) 15 1/4

Major findings:
Of operations _____
Of autopsy _____

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? Y

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

23. Signature J. P. [unclear] (M. D. or other) _____

Address Lexington Date signed July 19 1940

Cope 3/11/6

RECEIVED
District Health Officer No. 8,
State File Number
Date Filed *3-11-6*

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.