

No. 2
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1-17-39
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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED SEP 21 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29975

State File No. _____

Registrar's No. 276

Registration District No. 47

Primary Registration District No. 3008

14
1
2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: *Callaway*

(a) County _____

(b) City or town *Fulton*

(c) Name of hospital or institution: *State Hospital no 1 2*

(d) Length of stay: In hospital or institution *1 mo. 6 d.*

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED: 14

(a) State *Mo* (b) County *St. Francois* 1

(c) City or town *Bonne Terre* 2

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? *0* years.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME *Geo. W. Robinson*

3. (b) If veteran, name war *1918*

3. (c) Social Security No. *714*

20. DATE OF DEATH: Month *Aug.* day *23* year *1942* hour *3* minute *45 P.* M.

4. Sex *male* 5. Color or race *colored*

6. (a) ~~Single, widowed, married~~ divorced *3*

6. (b) Name of husband or wife *1918*

6. (c) Age of husband or wife if alive *1918* years

7. Birth date of deceased *OCT 10 1870*

21. I hereby certify that I attended the deceased from *July 17*, 19*42*, to *July 23*, 19*42*; that I last saw him alive on *Aug 23*, 19*42*; and that death occurred on the date and hour stated above.

Immediate cause of death *Chronic Myocarditis*

8. AGE:	Years	Months	Days	If less than one day
	<i>71</i>	<i>10</i>	<i>13</i>	_____ hr. _____ min.

Due to *generalized arteriosclerosis*

Due to *Blood syphilis*

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

Other conditions _____ (Include pregnancy within 3 months of death)

10. Usual occupation *gambler*

11. Industry or business _____

Major findings: Of operations _____

12. Name *Alck. Robison*

13. Birthplace *Mo. Car. 1* (City, town, or county) _____ (State or foreign country)

Of autopsy _____

PHYSICIAN *Gog*

Underline the cause to which death should be charged statistically.

14. Maiden name *Odella Smith* (City, town, or county) _____ (State or foreign country)

15. Birthplace *mo D* (City, town, or county) _____ (State or foreign country)

16. (a) Informant *Dora L. Robison*

(b) Address *Bonne Terre Mo*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

17. (a) *Removal* (b) Date thereof *Aug 24 1942*

(c) Place: burial or cremation *Bonne Terre Mo*

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

18. (a) Signature of funeral director *John H. Wallace*

(b) Address *Fulton Missouri*

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

19. (a) *8-24-1942* (Date received local registrar)

(b) *Josie Moravickoff* (Registrar's signature)

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

23. Signature *Formal Thomas D* (M. D. or other)

Address *Fulton Mo* Date signed *8/24/42*

1141

(Licensed Embalmer's Statement on Reverse Side) *State Hospital no 1*

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.....

James P. Cady, Registered Apprentice No. *329*
working under my personal supervision.

Signed *Albert E. White*

Licensed Embalmer No. *4168*

P. O. Address *Fulton, Mo.*

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.