

FILED MAY **2 1944**

Registration District No. **2**

Primary Registration District No. **3008**

Registrar's No. **181**

1. PLACE OF DEATH:  
 (a) County Callaway  
 (b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: State Hospital No. 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 yr 1 m (Specify whether years, months or days)  
 In this community 1 yr 1 m

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Callaway  
 (c) City or town Wallerburg  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 111  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country 1 2

3. (a) PRINT FULL NAME Christopher C. Robinson  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month April day 13  
 year 1944 hour 6-10 minute 0 M.  
 21. I hereby certify that I attended the deceased from 3-30-1944 to 4-13-1944  
 that I last saw him alive on 3-12-1944  
 and that death occurred on the date and hour stated above.

4. Sex male (1) 5. Color of race White  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife 51  
 6. (c) Age of husband or wife if alive deceased years 8  
 7. Birth date of deceased: Aug (Month) 8 (Day) 1848 (Year)

Immediate cause of death Myocarditis  
 Due to Pneumonia  
 Due to Arteriosclerosis  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

8. AGE: Years 95 Months 8 Days 6 If less than one day hr. min.  
 9. Birthplace Portland Oregon  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Farmer

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
 12. Name Thomas L. Robinson  
 13. Birthplace 56 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name Martha Jane Roberts  
 15. Birthplace Columbia Mo  
(City, town, or county) (State or foreign country)  
 16. (a) Informant Record

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) (b) Means of injury 0  
 23. Signature George H. Penco (M. D. or other) M.D.  
 Address Fulton Mo Date signed 4-12-44

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 15, 1944  
(Month) (Day) (Year)  
 (c) Place: burial or cremation Hill-Crest  
 18. (a) Signature of funeral director Wm J. Manspin  
 (b) Address 712 Court St. Fulton, Mo.  
 19. (a) Apr. 14-1944 (b) Josee Moscauff  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-8-44.....

**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.....

*Glen Y. Manspin*

Licensed Embalmer No. 2725.....

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.**

Registration District No. 47 Primary Registration District No. 3008

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Julesburg  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Christopher Robinson

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

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced w

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

7. Birth date of deceased aug 8  
(Month) (Day) (Year)

8. AGE: Years 95 Months 8 Days 6 If less than one day \_\_\_\_\_ min. \_\_\_\_\_

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

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

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

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

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

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis Duration \_\_\_\_\_

Due to Pneumonia & Lobes

Due to atherosclerosis

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

Major findings: Of operations \_\_\_\_\_ 108

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

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

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

**SUPPLEMENTAL**

14311

of the way

Reem M.D.

W. L. W.