

FILED MAY 10 1944  
Registration District No.

Primary Registration District No. 5522

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Prairie  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jackson County G. Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days (Specify whether years, months or days)

In this community 65 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 309 S. Pleasant  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sally Robinson

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female | 5. Color or race wh.

6. (a) Single, widowed, married, divorced w. 2

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased June 26 1878  
(Month) (Day) (Year)

8. AGE: Years 65 Months 9 Days 7 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired

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

MOTHER FATHER

12. Name Joseph Hellberg

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

14. Maiden name Sarah Land

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

16. (a) Informant Geo. Robinson

(b) Address 309 S. Pleasant 2nd mo

17. (a) Burial (b) Date thereof 4-4-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove mo

18. (a) Signature of funeral director [Signature]

(b) Address Oak Grove mo

19. (a) April 3, 1944 (b) F. M. Schick  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2nd  
year 1944 hour 2 minute 45 P. M.

21. I hereby certify that I attended the deceased from March 23rd, 1944, to April 2, 1944, that I last saw her alive on April 2, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary heart failure

Duration \_\_\_\_\_

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

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

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

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? \_\_\_\_\_

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

22. Signature of F. W. Tuttle (M. D. or other) MD

Address Blue Springs Mo Date signed 4/4/44

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**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.....

*R. B. Webb*

Licensed Embalmer No. *2353*

P. O. Address.....

*Blue Spring 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.**