

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 159

FILED OCT 13 1944

Registration District No. 324

Primary Registration District No. 2072

1. PLACE OF DEATH:

(a) County Saline

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

(c) Name of hospital or institution: Fitzgibbons Hospital
(If not hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 days
Specify whether

In this community 54 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline

(c) City or town Marshall 97
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Margaret Agnes Robertson

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 Widowed

6. (b) Name of husband or wife Josiah J. Robertson

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

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>Unknown</u>			hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Weisman

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

14. Maiden name Arnie Tracht

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

16. (a) Informant Marion Robertson

(b) Address Marshall Mo.

17. (a) Burial (b) Date thereof Sept 8, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ridge Park Cem.

18. (a) Signature of funeral director Campbell Lewis

(b) Address Marshall Mo.

19. (a) Sept 7-44 (b) Mrs. J. Weisman
(Date of local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5
year 1944 hour 11 minute _____ M.

21. I hereby certify that I attended the deceased from Sept 5 to Sept 14, 1944
and that death occurred on the date and hour stated above.

that I last saw h. ee alive on Sept 5, 1944

Immediate cause of death Fracture of Hip

Due to Quemura

Due to _____

Other conditions 1-10-15
(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) accident

(b) Date of occurrence _____

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

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

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

3. Signature John P. Laerman (M. D. or other) fall
Address Marshall, Mo. Date signed Sept 6-44

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

17-1-2

1215

RECEIVED

District Health Officer No. 8

District File Number

10-12-4-1

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

Registered Apprentice No.

working under my personal supervision.

Signed

P. W. Campbell Jr.

Licensed Embalmer No.

3469

P. O. Address

Marshall, 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.