

No. 5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41293

FILED JAN 6 1945

Registration District No. 138

Primary Registration District No. 3-3-26

Registrar's No. 5

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

1. PLACE OF DEATH:

(a) County Hickory

(b) City or town Preston & Union Mo.
(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) 1

(d) Length of stay: In hospital or institution 1
(Specify whether allof life)

In this community allof life
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Hickory 42

(c) City or town Preston
(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 _____

3. (a) PRINT FULL NAME Mary Winnie Robertson

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 6
year 1944 hour 11 minute 45 A.M.

21. I hereby certify that I attended the deceased from June 18
1944, to Aug 6 1944;
that I last saw him alive on Aug 4 1944;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race w

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

6. (b) Name of husband or wife James M. Robertson

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased (Month) 6 (Day) 16 (Year) 1868

Immediate cause of death Arterio Sclerotic - renal disease

Due to Senility

Due to _____

Other conditions (include pregnancy within 3 months of death) 1310

8. AGE: Years 76 Months 1 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Ernst Brandel 4

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

14. Maiden name Lucie Brockmeier

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations _____

Of autopsy _____

16. (a) Informant Mamie Lou Robertson

(b) Address Preston, Mo

17. (a) Burial (b) Date thereof 8-8-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bourne Chapel

18. (a) Signature of funeral director Wheatland

(b) Address Wheatland, Mo

19. (a) Dec 16 - 44 (b) Mary H. Carlstrom
(Date received local registrar) (Registrar's signature)

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) Means of injury 2

23. Signature C. A. Gaskin (M. D. or other) do

Address Herrington Date signed Dec 7

RECEIVED

District Health Officer No. 7,

District File Number 12-44-1430

Date Filed 1-6-40

31016

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 Charles Gilbert Putnam

Licensed Embalmer No. 4247

P. O. Address Wheatland, Md

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. 134 Primary Registration District No. 5526

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

1. PLACE OF DEATH:

(a) County Hickory

(b) City or town Preston Stack
(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 _____ years, months or days

3. (a) PRINT FULL NAME May 2 Robertson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race w

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive 16 years

7. Birth date of deceased: June 16 1906
(Month) (Day) (Year)

8. AGE: Years 26 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (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 _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) May 2 Robertson (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 June day 16 year 1906 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ 19 _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

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)

(c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

31016