

**FILED** AUG 4 1945

Registration District No. \_\_\_\_\_ Primary Registration District No. 5551

1. PLACE OF DEATH:

(a) County West Plains Rt 3

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

(c) Name of hospital or institution: Hospital room 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 16 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Howell

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

(d) Street No. Route 3- (If rural, give location)

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

3. (a) PRINT FULL NAME Jillie Belle Robinson

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 7 year 1945 hour 7 minute 45 P. M.

21. I hereby certify that I attended the deceased from 2-20, 1945, to 5-18, 1945, that I last saw her alive on 4-24, 1945, and that death occurred on the date and hour stated above.

4. Sex 71 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Geo W Robinson 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased: 10/19 (Month) (Day) (Year)

Immediate cause of death: Chronic Cardiac Valvular disease - Mitral

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

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

Other conditions (include pregnancy within 3 months of death) 1 2/3 W

Major findings: menopausal psychoneurosis

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

8. AGE: Years 51 Months 6 Days 29 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER { 11. Industry or business \_\_\_\_\_

FATHER { 12. Name Henry Allen

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

14. Maiden name Margaret Galt

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

16. (a) Informant G W Robinson

(b) Address West Plains, Mo Rt 3

17. (a) B (Burial, cremation, or removal) (b) Date thereof 5-22-45 (Month) (Day) (Year)

(c) Place: burial or cremation Union Grove

18. (a) Signature of funeral director Bob Jones

(b) Address West Plains, Mo

19. (a) 5-45 (Date received local registrar) (b) Bob Jones (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 \_\_\_\_\_

23. Signature Elet Jones (M. D. or other) ms

Address West Plains, Mo Date signed 6-12-45

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

16  
0  
0

1125

RECEIVED

District Health Officer No. 5,  
District File Number 845316  
Date Filed 8-13-48

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 A. D. Roberts

Licensed Embalmer No. 3435

P. O. Address Wheatville, 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.