

No. 2
8-43
-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

27790

FILED AUG 18 1945 **STANDARD CERTIFICATE OF DEATH**

State File No. _____

Registration District No. 178

Primary Registration District No. 5664

Registrar's No. 52

1. PLACE OF DEATH:

(a) County Lewis
 (b) City or town Williamstown, Missouri
 (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 Entire Life
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis
 (c) City or town Williamstown
 (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 MARION EUGENE ROBINSON

3. (b) If veteran, name war NONE
 3. (c) Social Security No. NONE

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife Katherine Betty
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 1 1949
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>4</u>	<u>2</u>	hr. _____ min.

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

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name John Robinson
 13. Birthplace Lewis Co. Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Katherine Croak
 15. Birthplace Marion Co. Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Marion Robinson

(b) Address Williamstown, Mo.

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

(c) Place: burial or cremation Deer Ridge Mo.

18. (a) Signature of funeral director W. C. Todd

(b) Address Carlow, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3
year 1945 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from May 1
1945 to July 3, 1945;

that I last saw him alive on July 3, 1945;

and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Atherosclerosis of Pericardium

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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? _____
(Specify type of place) (e) Means of injury _____

23. Signature W. C. Todd (M. D. or other) _____

Address Williamstown, Mo. Date signed 7/9/45

Duration

3 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

981

RECEIVED

District Health Officer No. 10

District File Number 8-45-1273

Date Filed AUG 16 1945

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

E. N. Barkley

Licensed Embalmer No.

2615

P. O. Address

Canton, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5 Sept
Registrar's No. 52

Registration District No. 178 Primary Registration District No. 5664

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Williamstown
(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)

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 _____

3. (a) PRINT FULL NAME Marion E. 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 _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased mar 1 (Month) (Day) (Year)

8. AGE: Years 66 Months 4 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 _____

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) July 10, 1945 (b) P. W. J... (Registrar's signature) (M. D.)
(Date received local registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1945 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; 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 _____

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 _____

SUPPLEMENTARY

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

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

MOTHER FATHER

S-27790