

Registration District No. 206

Primary Registration District No. 4317

1. PLACE OF DEATH: Madison
 (a) County Madison
 (b) City or town Marquand
 (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 most of life years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Madison
 (c) City or town Marquand MO
 (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 TERNECIA-ADELINE-ROBBINS
 3. (b) If veteran, name war ✓
 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 8 day 29
 year 1945 hour _____ minute _____ M.

4. Sex 71 5. Color or race W
 6. (a) Single, widowed, married, divorced W
 6. (b) Name of husband or wife W.M. Robbins
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct. 20 1864
 (Month) (Day) (Year)

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

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>10</u>	<u>10</u>	hr. _____ min.

Immediate cause of death Infirmities of old age
 Due to Myocarditis
 Due to _____

9. Birthplace Marquand MO
 (City, town, or county) (State or foreign country)
 10. Usual occupation house wife

Other conditions (include pregnancy within 3 months of death)
 Major findings: Of operations none
 Of autopsy none

11. Industry or business _____
 12. Name unknown
 13. Birthplace (City, town, or county) (State or foreign country)
 14. Maiden name unknown
 15. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant M.D. Robbins
 (b) Address Marquand MO
 17. (a) burial (b) Date thereof 9-2-45
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Marquand Cemetery
 18. (a) Signature of funeral director [Signature]
 (b) Address [Address]
 19. (a) 9-15-1945 (b) [Signature]
 (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) no
 (b) Date of occurrence no
 (c) Where did injury occur? no
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? no (e) Means of injury no
 23. Signature W.E. Bruner M.D. Coroner
 (M. D. or other)
 Address Federicktown Date signed 9/1/45

1566

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

RECEIVED

District Health Officer No. 4
District File Number 1045-1132
Date Filed 10-2-45

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 _____

S. L. (Bill) Duncan, Registered Apprentice No. 390
working under my personal supervision.

Signed

John H. Kelt
Licensed Embalmer No. 4264

P. O. Address Fredensborg, 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.