

FILED FEB 5 1947

State File No. ....

Registration District No. 324

Primary Registration District No. 3072

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall

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

(d) Length of stay: In hospital or institution one week  
(Specify whether years, months or days)

In this community 65 years near Slater

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline

(c) City or town Slater  
(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 Robert Lee Hains

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 11th  
year 1947 hour 10 minute p. M.

3. (b) If veteran, name war no

3. (c) Social Security No. none

21. I hereby certify that I attended the deceased from Jan - 2 1947 to Jan. 11 1947  
that I last saw him alive on Jan. 11 1947  
and that death occurred on the date and hour stated above.

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Rosa Hains

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased: February 25 1868  
(Month) (Day) (Year)

Immediate cause of death: Heart block  
Coronary Arteriosclerosis  
Chronic Nephritis  
Diabetes Mellitus

Due to .....

Due to .....

Other conditions: .....

Duration 17 days  
?  
20 yrs.

8. AGE: Years 80 Months 10 Days 16  
If less than one day .....

Major findings: .....

Of operations: .....

Of autopsy: 61

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

10. Usual occupation retired business man

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? .....

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

While at work? .....

(Specify type of place) (or Means of injury)

23. Signature O. G. McBurney (M. D. or other)  
Address Slater, Mo. Date signed 1/13/47

11. Industry or business .....

12. Name Geo. C. Hains

13. Birthplace Va.

14. Maiden name Elizabeth McCort

15. Birthplace Ohio

16. (a) Informant Mrs. R. L. Hains  
(b) Address Slater, Mo.

17. (a) burial (b) Date thereof 1-14-'47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Slater--Mo.

18. (a) Signature of funeral director Hill Brothers,  
(b) Address Slater--Mo.

19. (a) 1-14-47 (b) Mrs. T. Westbrook  
(Date received local registrar) (Registrar's signature)

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

17  
1  
2

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

1-25-47

MAR 20 1947

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. C. Hill

Licensed Embalmer No. \_\_\_\_\_

3090

P. O. Address \_\_\_\_\_

St. Louis - 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.