

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24833**
Registrar's No. **264**

Registration District No. **209**

Primary Registration District No. **3043**

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

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution: St. Elizabeth Hosp. 0
(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 Albert Earl Robey

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Etta Robey

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased: June 24, 1881
(Month) (Day) (Year)

8. AGE: Years 66 Months - Days 19 If less than one day hr. _____ min. _____

9. Birthplace: Lakenan Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business IX

MOTHER FATHER { 12. Name William A. Robey

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

14. Maiden name Mary Alice Abell

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

16. (a) Informant Mrs. A. E. Robey

(b) Address Lakenan Missouri

17. (a) Burial (b) Date thereof 7/16/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lakenan Missouri

18. (a) Signature of funeral director [Signature]

(b) Address 902 Broadway Hannibal Missouri

19. (a) 7-14-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby **102**

(c) City or town Lakenan **0**
(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 July day 13
year 1947 hour 7 minute 05 P.M.

21. I hereby certify that I attended the deceased from July 10 1947 to July 13 1947 that I last saw him alive on July 13 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Injury - at base
injury: total fracture
Base of skull on head
while pulling into barn

Due to _____

Due to _____

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

Duration

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

15 E

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) yes as above

(b) Date of occurrence July 10 & 17

(c) Where did injury occur? house
(City or town) (County) (State)

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

While at work? yes (Specify type of place) _____

(e) Means of injury blow

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

Address Hannibal Date signed July 14-47

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..... *W. Crawford Smith*

Licensed Embalmer No..... 3814

P. O. Address..... Hannibal Missouri

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.