

FILED JUL 13 1948

Registration District No. 290

Primary Registration District No. 4442

Registrar's No.

1. PLACE OF DEATH:

(a) County ~~Washington~~ Randolph
(b) City or town Higbee Mo.
(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 56yrs 7mo 28da.
years, months or days)

3. (a) PRINT FULL NAME James R. Robb.

3. (b) If veteran, name war World War I 3. (c) Social Security No.

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Scottie Robb 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct 28 1891
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
56 7 28 hr. min.9. Birthplace Howard Co. Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name W. A. Robb 0

13. Birthplace Howard Co. Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Betty Featherstone

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

16. (a) Informant Mr Estil Robb

(b) Address Higbee Mo

17. (a) Burial (b) Date thereof June 28 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sharon Church

18. (a) Signature of funeral director Joe W Burton

(b) Address Higbee Mo.

19. (a) (b) J. W. Wynn, M.D.
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph 88

(c) City or town Higbee
(If outside city or town limits, write "RURAL") 000

(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 June day 26
year 1948 hour I minute 45 a.m.21. I hereby certify that I attended the deceased from March 1948 to June 26 1948
that I last saw him alive on June 26 1948
and that death occurred on the date and hour stated above.

Immediate cause of death

Circumstances of death

Duration

3 mo

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations

Of autopsy

PHYSICIAN

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)

(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) (a) Means of injury

23. Signature J. W. Wynn, M.D. (or other)

Address Higbee Mo Date signed 7-2-48

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

5-33
1-33
X36671

JUL 10 1948

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. W. Freemont*.....

Licensed Embalmer No. *3978*.....

P. O. Address. *Glasgow, 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.

Registration District No. 390

Primary Registration District No. 442

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

1. PLACE OF DEATH:

(a) County: Randolph
(b) City or town: Highland
(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)

3. (a) PRINT FULL NAME: June R. Robt

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: m

6. (b) Name of husband or wife: _____ 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: Feb 28 (Month) (Day) (Year)

8. AGE: Years 56 Months 7 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: _____

MOTHER FATHER { 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) _____ (Date received local registrar) (b) [Signature] (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Year 1946 Hour 12 minute 06 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: _____

Duration _____
PHYSICIAN _____
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) _____
(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

S-20489