

U.S. No. 2
Form 8-43
Rev. 5-17-39
I X37823

22640

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 12 1944

Registration District No. 324

Primary Registration District No. 3022

Registrar's No. 117

1. PLACE OF DEATH:

(a) County Selma
(b) City or town Marshall
(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 ARTHUR C. ROBARKER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Martha Crocker 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years 65 Months 0 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business Farm

12. Name Sam Crocker

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

14. Maiden name Martha Spears

15. Birthplace Unknown (City, town, or county) (State or foreign country) Mo 0

16. (a) Informant Bessie Crawford

(b) Address Marshall Miss

17. (a) Burial (b) Date thereof 6-26-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home Selma, Mo

18. (a) Signature of funeral director F. F. Ferguson

(b) Address Selma, Mo

19. (a) 6-26-44 (b) Miss G. O. Westlake
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Selma 97

(c) City or town Marshall 1
(If outside city or town limits, write "RURAL") 2

(d) Street No. none (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 24
year 1944 hour 7:30 minute A M.

21. I hereby certify that I attended the deceased from June
1944 to June 24th 1944
that I last saw him alive on 6-24 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular Heart Disease
Duration 1 year or more

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 92d

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? _____

(Specify type of place) _____ While at work? (e) Means of injury _____

23. Signature W. T. Madison (M. D. or other) _____

Address Marshall, Mo Date signed 6-26-44

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

7-11-47

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

F. D. Ferguson

Licensed Embalmer No.

2182

P. O. Address

Sedalia

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.