

1938 JAN 14 1938

Noland

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

43159
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 316
(b) Township St. Louis Primary Registration District No. 5439
(c) City SPRINGFIELD (d) Street No. R#6
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Emma F. Robberson
(a) Residence, No. R#6 St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ed. F. Robberson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 1, 1874
7. AGE YEARS 64 MONTHS 6 DAYS 17 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc. In Home
10. Date deceased last worked at this occupation (month and year) ✓ 11. Total time (years) spent in this occupation ✓

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER 13. NAME Joe J. Hall

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Leola Lowe

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Ed. F. Robberson

18. BURIAL, CREMATION, OR REMOVAL Green Lawn Cemetery Dec 22 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. W. Wynn, 218 N. 1st St., Springfield, Mo.

20. FILED Dec 21 1938 Chas. G. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec - 18 1938

22. I HEREBY CERTIFY, That I attended deceased from 14 Dec 1938 to Dec 18 1938
I last saw him alive on Dec 17 1938 Death is said to have occurred on the date stated above, at 12:15 P.M.

The principal cause of death and related causes of importance were as follows:
Coronary & liver
Gal bladder infection

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....

(Signed) Dr. George S. Noland
(Address) 815 Noland Bldg

WRITE LEGIBLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X14023

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 J. B. Klingner
Licensed Embalmer No. 3358
P. O. Address Springfield 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, above space should be left blank.

WRITE PAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

43 15-9 Do not use this space.

1. PLACE OF DEATH (a) County: Greene (b) Township: Campbell (c) City: (d) Street No.: (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. moa. ds. (g) Registered No.: 982

2. PRINT FULL NAME: Emma F Roberson (a) Residence, No.: (Usual place of abode, if no street address, write county or city) St.: (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F 4. COLOR OR RACE: W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): m 6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 64 6 17 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 9. Industry or business in which work was done, as saw mill, bank, etc. 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 13. NAME 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 15. MAIDEN NAME 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 17. INFORMANT (ADDRESS) 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19. FUNERAL DIRECTOR (ADDRESS) 20. FILED 19

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 18 1928 22. I HEREBY CERTIFY, That I attended deceased from 19 to 19 I last saw him alive on 19 Death is said to have occurred on the date stated above, at m. The principal cause of death and related causes of importance were as follows: cirrhosis of liver Gall Bladder infection Case diagnosed from symptoms liver enlarged, jundice. Pain over gall bladder. No exrays. n. m. 10 - Other contributory causes of importance: 12412 Name of operation Date of What test confirmed diagnosis? Was there an autopsy? 23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19 Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place. Manner of injury Nature of injury 24. Was disease or injury in any way related to occupation of deceased? If so, specify (Signed) Dr. Geo. L. Noland M. D. (Address) Springfield mo

SUPPLEMENTARY

Local Registrar.

