

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

10871
Do not use this space.

APR 11 1939

1. PLACE OF DEATH

(a) County Greene Registration District No. 326
 (b) Township Center Primary Registration District No. 5443
 (c) City _____ (d) Street No. _____ St. _____
 (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. mos. ds.

2. PRINT FULL NAME Martha ~~Cornelia~~ Robertson

(a) Residence, No. Boisd Arc No St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Marion Robertson</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 15, 1862</u>		
7. AGE	YEARS <u>76</u>	MONTHS <u>9</u>
	DAYS <u>19</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>	
	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) <u>Greene County</u>		
FATHER	13. NAME <u>Oren Carter</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Wisconsin</u>	
MOTHER	15. MAIDEN NAME <u>Malinda Davis</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>	
17. INFORMANT (ADDRESS) <u>Mr. Marion Robertson Boisd Arc</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Clear Creek</u> DATE <u>March 6, 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Brian Funeral Service Ash Grove Mo</u>		
20. FILED <u>4/3/10</u> 19 <u>39</u> <u>Luay E. Hays</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 5th, 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-1-, 1930, to 3-5-, 1939
 I last saw h. alive on 2-4-, 1939. 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:
Chronic Bronchitis
106 B-1
 Other contributory causes of importance:
Atherosclerosis

Name of operation _____ Date of _____
 What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no 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? no
 If so, specify _____
 (Signed) R. S. Stinson, M. D.
291 (Address) Boisd Arc Mo

WRITE PLAINLY, 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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.