

RECORDED MAY 12 1939

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

15615
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 55
(b) Township Anderson Primary Registration District No. 6262 Registered No. 1267
(c) City Madison, Mo or (d) Street No. _____ St.
(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 4 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME ESTER ROBINSON

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

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 JOE ROBINSON
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1863? 1-20-1863
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
176 3 2
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. own home
10. Date deceased last worked at this occupation (month and year) 4/11/39 11. Total time (years) spent in this occupation 18 yrs
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison, Mo
13. NAME do not know
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) do not know
15. MAIDEN NAME do not know
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) do not know

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/22/39, 1939
22. I HEREBY CERTIFY, That I attended deceased from 4:15, 1939, to _____, 1939.
I last saw her alive on 4:15, 1939. Death is said to have occurred on the date stated above, at 10 A m.
The principal cause of death and related causes of importance were as follows:

Senility

Date of onset

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 _____, 1939
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) J. S. Hopkins, M. D.
541 (Address) Madison, Mo

17. INFORMANT JOE ROBINSON
(ADDRESS) Madison Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Shoemaker Cem DATE 4-23-39
19. FUNERAL DIRECTOR (NAME) Wm. Leach
(ADDRESS) Richard Mo
20. FILED May 10, 1939 M. O. Munnica
Local Registrar.

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.