

WHITE 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.

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

36078
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE
(b) Township SPRINGFIELD
(c) City SPRINGFIELD

Registration District No. 378
Primary Registration District No. 2001

Registered No. 767

(d) Street No. 709 Normal St. Gerrit
(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. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

CLAUDIA ROBINSON

(a) Residence, No. 709 Normal St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OF RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Robinson WIFE OF Claudia Robinson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 4 1855

7. AGE YEARS 83 MONTHS 10 DAYS 14 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Ret. Grocerman
9. Industry or business in which work was done, as saw mill, bank, etc. in Store
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) Landon, Kentucky

13. NAME Thomas Robinson

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

15. MAIDEN NAME Mary McNeil

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

17. INFORMANT (ADDRESS) Mrs. Claudia Robinson

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Park DATE Oct. 21 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alma Schreyer

20. FILED Oct 21 39 Charl. W. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 18, 1939

22. I HEREBY CERTIFY, That I attended deceased from October 18, 1939, to October 18, 1939

I last saw him alive on October 18, 1939. Death is said to have occurred on the date stated above, at 12:30 P.

The principal cause of death and related causes of importance were as follows:

Congestive Heart Failure Terminal

Other contributory causes of importance: hypertension

Name of operation None Date of 1935

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? _____ 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) Therese Coffey M. D.
(Address) 518 Hancock Bldg. Springfield, Mo.

2002

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STATE OF ILLINOIS
DEPARTMENT OF HEALTH
DIVISION OF PROFESSIONAL REGULATION

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.....

Clas C George

Registered Apprentice No. *204*

working under my personal supervision.

Signed *Harlow Knab*

Licensed Embalmer No. *4065*

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.

X

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

36078
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 318
(b) Township Springfield Primary Registration District No. 2001
(c) City Springfield (d) Street No. _____ Registered No. 767
(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.
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME

(a) Residence, No. Herritt Robman 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
93 10 14

OCCUPATION 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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 12-15-39 Chas. A. George, M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 18, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

I last saw h. _____ 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:

Congestion Heart Failure
Chronic Myocarditis
Date of onset _____

Other contributory causes of importance:

Hypertension 1935

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) Seymour H. Coffelt, M. D.

(Address) Springfield, Mo.

SUPPLEMENTARY

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.

