

Dr. Mc. Daniel
MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

14801

Do not use this space.

1. PLACE OF DEATH

(a) County Dunklin Registration District No. 287
 (b) Township Clay Primary Registration District No. 2400 Registered No. ?
 or
 (c) City D(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 yrs. mos. 1 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Shelby Gean Robinson

(a) Residence, No. Rives, Mo. 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) Infant		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant		6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 19, 1939		
7. AGE		YEARS	MONTHS	DAYS
				1
		If LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None			
	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) Rives (STATE OR COUNTRY) Mo.				
FATHER	13. NAME J. Robinson			
	14. BIRTHPLACE (CITY OR TOWN) Chaffee (STATE OR COUNTRY) Mo.			
MOTHER	15. MAIDEN NAME Elsie Wilkins			
	16. BIRTHPLACE (CITY OR TOWN) Senath (STATE OR COUNTRY) Mo.			
17. INFORMANT J. Robinson (ADDRESS) Rives, Mo.				
18. BURIAL, CREMATION, OR REMOVAL PLACE Wilkins Cem DATE Jan 20 19 40				
19. FUNERAL DIRECTOR (NAME) German Undt Co. (ADDRESS) Steele, Mo.				
20. FILED 4/25-40 19 40 Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan 20**, 19 **40**

22. I HEREBY CERTIFY That I attended deceased from Deliver like Shelby alone, 19 40, to alone, 19 40.
 I last saw h. _____ alive on _____, 19 40. Death is said to have occurred on the date stated above, at 2.00 m.
 The principal cause of death and related causes of importance were as follows:
it must have frozen to death.

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 40
 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. R. [Signature], M. D.
 (Address) Steele, Mo.

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.

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RECEIVED

District Health Officer No.

District File Number 540-92

Date Filed 5/2/40

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.