V. S. No. 2
M—11-10-39
Rev. 5-17-39
I X21492

40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED JUN 20 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18516

Registration District No. 328 Primary Registration District No. 5452 Registrar's No.

1. PLACE OF DEATH

(a) County: Grundy

(b) ~~City or town~~: Rural Route # 5 Madison (If outside city or town limits, write "RURAL" and name of township) Twp

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days) In this community 11 2

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town: Trenton Mo. Rural Rt. # 5 (If outside city or town limits write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Randolph McDonald Robertson

3. (b) If veteran, name war:

3. (c) Social Security No. 486-12-7158

4. Sex: Male

5. Color or race: white

6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: Oct (Month) 29 (Day) 1884 (Year)

8. AGE: Years 55 Months 5 Days 7 If less than one day hr. min.

9. Birthplace: Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business:

FATHER 12. Name: William Robertson

13. Birthplace: Missouri (City, town, or county) 0 (State or foreign country)

MOTHER 14. Maiden name: Minerva McCammon

15. Birthplace: Missouri (City, town, or county) 0 (State or foreign country)

16. (a) Informant: John Robertson

(b) Address: Rt 5 Trenton

17. (a) Elmburg (Burial, cremation, or removal) (b) Date thereof: 4. 9. 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Elmburg

18. (a) Signature of funeral director: Chas W Spon

(b) Address: Trenton Mo.

19. (a) 4-7-40 (Date received local registrar) (b) Irene D Fair (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 6. year 1940 hour 7. minute 0 M.

21. I hereby certify that I attended the deceased from March 30th, 1940, to April 6th, 1940; that I last saw him alive on ~~April~~ April 4th, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Lung Abscess (Left) — Duration ??

Due to: Complication

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations:

Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 3 00 (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Oliver F. Duffy (M. D. or other) M.D.

Address: Trenton, Mo. Date signed April 8th 1940

(Licensed Embalmer's Statement on Reverse Side)

1148

RECEIVED
District Health Officer No. 11
District File Number 640-894
Date Filed JUN 12 1940

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 Chas D Gypson

Licensed Embalmer No. 3109

P. O. Address Trenton

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.

. S. No. 2B
M—2-21-40
I xx

WOWENA MOORE

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18516

Registration District No. 328 Primary Registration District No. 5432 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Grundy
(b) ~~City or town~~ Madison T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Randolph McDonald Robertson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex m
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 55 Months 5 Days 7 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 6 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.
Immediate cause of death Lung abscess Infection (Left)
Due to Probably Spirichtosis from Infected gums
Due to
Other conditions
(Include pregnancy within 3 months of death)
114 B?
Major findings:
Of operations
Of autopsy

Duration
about 2 months ??

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature Oliver F Duffey (M.D. or other)
Address Trenton Date signed 1/40