

MAY 19 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28617

Registration District No. 347

Primary Registration District No. 3018

Registrar's No.

## 1. PLACE OF DEATH

(a) County Henry Clinton  
 (b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 303 W Gravel 2  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community 58 yrs  
years, months or days)

3. (a) PRINT FULL NAME John A Robertson

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced M  
 6. (b) Name of husband or wife Polonia Robertson 6. (c) Age of husband or wife if alive years  
 7. Birth date of deceased 7 6 1870  
(Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 18 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Osceola Mo  
(City, town, or county) (State or foreign country)10. Usual occupation Boiler Maker

## 11. Industry or business

MOTHER FATHER { 12. Name Samuel Robertson  
 13. Birthplace \_\_\_\_\_ Kentucky  
(City, town, or county) (State or foreign country)  
 14. Maiden name Malinda Jones  
 15. Birthplace \_\_\_\_\_ Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Polonia Robertson  
(b) Address Clinton Mo17. (a) Burial (b) Date thereof Aug 26 40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Englewood Cem18. (a) Signature of funeral director Ed Wilkinson  
(b) Address Clinton Mo19. (a) Sept 7 1940 (b) J. R. Farnpeter  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry  
 (c) City or town Clinton  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 303 W Gravel  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24  
year 1940 hour 12 minute 10 P. M.21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1934, to Aug 24, 1940;  
that I last saw him alive on August 24, 1940,  
and that death occurred on the date and hour stated above.Immediate cause of death Chronic myocarditis  
Duration 6 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions none  
(Include pregnancy within 3 months of death)Major findings: Of operations noneOf autopsy none

## 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? none  
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
312 none  
(Specify type of place) (e) Means of injury23. Signature S B Hughes (M. D. or other) 1  
Address Clinton Mo Date signed 8/26/40

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

12  
4  
2

5

RECEIVED

District Health Officer No. 7,

District File Number 9-40-1362

Date Filed 9-16-40

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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 Fred Wilkinson

Licensed Embalmer No. 2478

P. O. Address Clinton Ma

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.