

I X1851 USE UNFADING BLACK INK—MAKE 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.

Registration District No. **184**

Primary Registration District No. **4110**

Registrar's No. **22**

1. PLACE OF DEATH:

(a) County Christian

(b) City or town Osark
(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 2
(Specify whether)

In this community 65 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Christian

(c) City or town Osark
(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 William L. 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 widowed

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** alive 23 years
(Month) (Day) (Year)

7. Birth date of deceased Feb. 23 1868
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20
year 1940 hour 8 PM, minute _____ M.

21. I hereby certify that I attended the deceased from Oct 19, 1940, to Oct 20, 1940,
that I last saw him alive on Oct 19, 1940;
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>82</u>	<u>7</u>	<u>27</u>	hr. _____ min. _____

Immediate cause of death Shiga Dysentery **Duration** 2 days

Due to Shiga Bacillus

Due to _____

Other conditions Chr. Myocarditis
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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

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

10. Usual occupation Merchant

11. Industry or business

12. Name James W. Robertson

18. Birthplace Tennessee
(City, town, or county) (State or foreign country)

14. Maiden name Martha Payne

15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rose Robertson

(b) Address Osark Mo.

17. (a) (Burial, cremation, or other) Burial **(b) Date thereof** Oct 21 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Osark Cemetery

18. (a) Signature of funeral director T. B. Chaffin

(b) Address Osark Mo.

19. (a) Nov. 8-1940 **(b) (Registrar's signature)** Varilla Leonard
(Date received local registrar) (Registrar's signature)

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?
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While at work? (Specify type of place) (a) Means of injury

23. Signature Stanley H. Rorer (M. D. or other)

Address Osark Mo. **Date signed** 11-7-40

RECEIVED

District Health Officer No. 8;

District File Number 1140-2898

Date Filed NOV 19 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.....

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.