

Registration District No. 928

Primary Registration District No. 6040

Registrar's No.

1. PLACE OF DEATH:

(a) County Shelby
(b) City or town Rural - Jackson Township
(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) 20
(d) Length of stay: In hospital or institution. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert Leon Corbin

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. -

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

7. Birth date of deceased Sept 29 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
- - - 18 hr. min.

9. Birthplace Shelby Co Mo - 0
(City, town, or county) (State or foreign country)

10. Usual occupation 0

11. Industry or business 0

12. Name Robert Lawrence Corbin

13. Birthplace Shelby Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Margella Bess

15. Birthplace Pitts Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Lawrence Corbin

(b) Address Shelbina Mo

17. (a) Burial (b) Date thereof Sept. 30, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shelbina Mo.

18. (a) Signature of funeral director E. Hayes 150
(b) Address Shelbina Mo

19. (a) Oct. 11, 1940 (b) Mrs. Nell Landrum
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby
(c) City or town Shelbina Mo
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept - day 30
year 1940 hour 1:30 minutes 15 M.

21. I hereby certify that I attended the deceased from Sept 29
1940 to Sept 30; 140
that I last saw him alive on Sept 30, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death (Stenocardia)
Cerebral thrombosis
due to delivery

Due to _____
Due to difficult delivery

Other conditions 1600
(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?

While at work? _____ (Specify type of place)
(e) Means of injury 2

23. Signature W. Hayes (M. D. or other) 100
Address Shelbina Mo Date signed _____

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

2

RECEIVED

District Health Officer No. 10

District File Number 11-40-2064

Date Filed NOV 8 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.

Not Embalmed

Signed E. Harper

Licensed Embalmer No. 1487

P. O. Address Shelburne, Vt.

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.