

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

3549
Do not use this space.

1. PLACE OF DEATH
 (a) County New Madrid Registration District No. 5-8
 (b) Township Anderson Primary Registration District No. 6262 Registered No. 62
 (c) City Fidelity, mo. (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred 5 yrs. mos. ds. (f) How long in U.S., if of foreign birth? 72 yrs. mos. ds.

2. PRINT FULL NAME MARK HAZEL ROBINSON
 (a) Residence, No. Fidelity, mo. Rural St. 0 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Vernie Robinson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sep 30, 1910

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. min.
30 yrs. 5 mo 15 days

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife
 9. Industry or business in which work was done, as saw mill, bank, etc. own home
 10. Date deceased last worked at this occupation (month and year) 2-11-41 11. Total time (years) spent in this occupation 12 yrs.

12. BIRTHPLACE (CITY OR TOWN). (STATE OR COUNTRY) Opone, ark.

FATHER
 13. NAME Homer French
 14. BIRTHPLACE (CITY OR TOWN). (STATE OR COUNTRY) Unknown

MOTHER
 15. MAIDEN NAME Unknown
 16. BIRTHPLACE (CITY OR TOWN). (STATE OR COUNTRY) Unknown

17. INFORMANT Vernie Robinson
 (ADDRESS) Fidelity, mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Stanfield DATE Feb 16, 1941

19. FUNERAL DIRECTOR (NAME) W H Erby
 (ADDRESS) Wiggott ark.

20. FILED 2-17 1941 E. M. M. M. acting Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 15 - 1941

22. I HEREBY CERTIFY, That I attended deceased from 2-15-41, 19... to 2-15-41, 19...
 I last saw her alive on 2-15-41, 19... Death is said to have occurred on the date stated above, at 6:00 p.m.
 The principal cause of death and related causes of importance were as follows:
Pneumo-pneumonia, 2-12-41.

Date of onset

Other contributory causes of importance:
uterine hemorrhage.

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...
 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? no
 If so, specify _____
 (Signed) Jos Hopkins M. D.
 (Address) Fidelity, mo.

N. B.—Every item of information 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.

RECORD

107

RECEIVED

District Health Officer No. 2

District File Number 241-284

Date Filed 2/19/44

APR 1 1944

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.....

APR 1 1944

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3549

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 55

Primary Registration District No. 6262

Registrar's No.

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

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Anderson
(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 _____ (Specify whether _____)

years, months or days

3. (a) PRINT FULL NAME Mary Hazel Robinson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

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

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	Months	Days	If less than one day
<u>30</u>	<u>5</u>	<u>15</u>	hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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.

20. DATE OF DEATH Month Feb day 15 year 1941 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 Pneumonia

Due to uterine hemorrhage

Due to incomplete abortion 1st Trimester

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

Major findings: Of operations _____

Of autopsy _____

141A

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 _____

23. Signature J. H. Johnson (M. D. or other) _____

Address Paducah, Mo. Date signed 5-9-41

SUPPLEMENTAL

