DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 10 1942

5-17-39
X29484

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. Turner 37547

Registration District No. 200 | Primary Registration District No. 3041 | Registrar's No. 100

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

1. PLACE OF DEATH:
(a) County: Macon
(b) City or town: Macon
(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 years, months or days) In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Macon 61 3
(c) City or town: Macon 2
(If outside city or town limits, write "RURAL")
(d) Street No. .....
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Mollie Robinson
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex: Female
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: W — 9
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Nov (Month) 21 (Day) 1942 (Year)

8. AGE: Years 65 | Months 5 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace: Randolph Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Housekeeper
11. Industry or business .....
MOTHER FATHER
12. Name: David Blake
13. Birthplace: Mo (City, town, or county) (State or foreign country)
14. Maiden name: Amelia Blake
15. Birthplace: Mo (City, town, or county) (State or foreign country)
16. (a) Informant: Lon Nichols
(b) Address: Macon
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov 23-1942 (Month) (Day) (Year)
(c) Place: burial or cremation: Woodlawn Cem
18. (a) Signature of funeral director: Walt Skinner
(b) Address: Macon Mo
19. (a) 12/3/42 (Date received local registrar) (b) Nora B. Funckler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 21 year 1942 hour 7 minute 9 A.M.
21. I hereby certify that I attended the deceased from Nov. 19 1942 to Nov. 20 1942 that I last saw her alive on Nov. 20 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchial pneumonia	3 days
Due to: Generalized arteriosclerosis	15 yrs +
Due to:	
Other conditions (Include pregnancy within 3 months of death): 107	
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? ..... (Specify type of place)
While at work? ..... (e) Means of injury: 0
23. Signature: J. F. Turner (M. D. or other)
Address: Macon, Mo. Date signed: 12-3-42

1237 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 12-42-4012
Date Filed Dec 8, 1942

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 Aclant Skinner

Licensed Embalmer No. 751

P. O. Address Macon Ga

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

If this body is not embalmed, fact should be so stated above.

. S No. 2B
OM 3-21-41
I X29288

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STANDARD CERTIFICATE OF DEATH

State File No. 37547

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 100

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Macon
(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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mollie Robinson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased May 28, 1865 (Month) (Day) (Year)

8. AGE: Years 65 Months 5 Days 20 If less than one day hr. min.

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

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 Nov day 21 year 1942 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.

	Duration
Immediate cause of death	
Due to	
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)

(b) 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY