

FILED MAR 10 1943
Registration District No. _____

Primary Registration District No. 3038

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

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Brookfield
(c) Name of hospital or institution:
1536 Market St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 50 years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME LAURA-ADELLAH-ROBINSON

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex 7 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John W Robinson 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 19 - 1872 (Month) (Day) (Year)

8. AGE: Years 70 Months 4 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Ephraim Peters

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

14. Maiden name Mary Jane Baldwin

15. Birthplace Macon County Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Chester H Robinson

(b) Address Brookfield

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb-16-1943 (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery Brookfield

18. (a) Signature of funeral director Hill Chapel

(b) Address Brookfield

19. (a) 2-15-1943 (Date received local registrar) (b) H W Caman (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Linn 58
(c) City or town Brookfield 2 (If outside city or town limits, write "RURAL")
(d) Street No. 536 Market (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15 year 1943 hour 5:31 minute _____ M. P.
21. I hereby certify that I attended the deceased from July 1st, 1942 to Feb 13, 1943 that I last saw him alive on Feb 13 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive pneumoedema Duration _____
Due to Cardiac renal disease
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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (a) Means of injury _____
23. Signature H T Brownfield (M. D. or other) _____
Address Brookfield Mo Date signed 2/15/43

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

J. H. Blacklock

Licensed Embalmer No.

22166

P. O. Address

Brookfield Me

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6883

Registration District No. _____

Primary Registration District No. 3038

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(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 mo (b) County Linn
(c) City or town Brookfield
(If outside city or town limits, write "RURAL")
(d) Street No. 536 Market
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Laura A. Robinson

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month Feb day _____ year 1943 hour _____ minute _____ M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced md

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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

7. Birth date of deceased: Sept 19 - 1972
(Month) (Day) (Year)

Due to Aspetic pneumonia
bronchial pneumonia

8. AGE: Years 70 Months 4 Days _____ If less than one day _____ min.

Due to _____

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

Other conditions: Heart/renal insufficiency
(Include pregnancy within 3 months of death)

10. Usual occupation _____

11. Industry or business _____

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

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)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

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? _____

18. (a) Signature of funeral director _____ (b) Address _____

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

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

23. Signature J. W. Arnold M.D. (M. D. or other) _____
Address Brookfield Mo Date signed 3/2/43

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

SUPPLEMENTARY

MOTHER FATHER

