

S. No. 2
-14-41
5-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9867**
Registrar's No. **86**

Registration District No. **53** Primary Registration District No. **3010**

16
4
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County **Cape Girardeau**
(b) City or town **Cape Girardeau**
(c) Name of hospital or institution: **Southeast Hosp**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **16 days**
In this community **16 days**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Fay Ann Robinson**
3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **divorced baby**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Feb. 26 1943**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days **16** If less than one day _____ hr. _____ min.

9. Birthplace **Cape Girardeau Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name **Neeb Robinson**
13. Birthplace **Thomasville Ill.**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Seelig**
15. Birthplace **Oran Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Hospital Records Dept**
(b) Address **Oran Mo**

17. (a) **Burial** (b) Date thereof **3-15-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cape Co Mo**

18. (a) Signature of funeral director **B. L. Spingarn**
(b) Address **Chaffee Mo**

19. (a) **3-19-43** (b) **H. H. Phelps**
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **14th**
year **1943** hour **10** minute **45 P.M.**
21. I hereby certify that I attended the deceased from **Feb 26**
~~Jan 26~~ 1943 to **March 14** 1943.
that I last saw her alive on **March 14th** 1943.
and that death occurred on the date and hour stated above.

Immediate cause of death **Iles Colitis** Duration **5 days**

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) **1190**

PHYSICIAN
Major findings: Of operations _____
Of autopsy _____
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 **H. H. Phelps** (M. D. certifier)
Address **Cape Girardeau Mo** Date signed **3/14/43**

RECEIVED

District Health Officer No. 4

District File Number 443-2054

Date Filed 4-7-43

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 ^{not} _____, Registered Apprentice No. _____, working under my personal supervision.

Signed Mamie Bespleyhoff

Licensed Embalmer No. 5272

P. O. Address Chapbee Md

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.