

V. S. No. 2
FORM--2-43
5-17-39
X35897

28102

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

LED SEP 9 1943

Registration District No. _____

Primary Registration District No. 4165

Registrar's No. 87

31
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Daviess

(b) City or town Gallatin
(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 Most of Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Daviess

(c) City or town Gallatin
(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 _____

3. (a) PRINT FULL NAME William Givens Robertson

3. (b) If veteran, name war None

3. (c) Social Security No. 493-18-9542

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Lelia Robertson

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased April 3 1867
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>76</u>	<u>4</u>	<u>10</u>	hr. _____ min.

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

10. Usual occupation Printer

11. Industry or business Newspaper

MOTHER FATHER {

12. Name James Robertson

13. Birthplace Unknown 7
(City, town, or county) (State or foreign country)

14. Maiden name Rachiel Hodgsett

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

16. (a) Informant Mrs. Lelia Robertson

(b) Address Gallatin, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-1943
(Month) (Day) (Year)

(c) Place: burial or cremation L.O.O.F. Cemetery

18. (a) Signature of funeral director Hope Furn. & Undt. Co

(b) Address Gallatin, Mo.

19. (a) 8-16-1943 (Date received local registrar) (b) L.O. Fishery (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13
year 1943 hour 12 minute NOON M.

21. I hereby certify that I attended the deceased from 8/13
1943 to 8/13 1943
that I last saw him alive on 8/13 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Senile Dementia (yr)

Due to Deterioration of brain cells

Due to _____

Other conditions (Include pregnancy within 3 months of death) 1620

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 _____

23. Signature M. B. Bailey (M. D. or other)

Address Gallatin, Mo. Date signed 8/16/43

1087

(Licensed Embalmer's Statement on Reverse Side)

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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.....

L. O. Richesson

Licensed Embalmer No. *3302*

P. O. Address *Fallatio Mo.*

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.