

SEP 10 1943

Registration District No. **128** Primary Registration District No. **2000c**

1. PLACE OF DEATH:

(a) County **GREEN**  
(b) City or town **Springfield**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**1201 N. Park**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **April 15, 1943**  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Green 39**  
(c) City or town **Springfield, Mo. 2**  
(If outside city or town limits, write "RURAL") **6**  
(d) Street No. **1201 N. Park**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country **NO** **0**

3. (a) PRINT FULL NAME **DELLA Robinson**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **William T. Robinson** 6. (c) Age of husband or wife if alive **unk.** years

7. Birth date of deceased **Sept 21 1876**  
(Month) (Day) (Year)

8. AGE: Years **66** Months **11** Days **2** If less than one day hr. min.

9. Birthplace **unk. unk?**  
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business \_\_\_\_\_

12. Name **unable to obtain**

13. Birthplace **unk. unk?**  
(City, town, or county) (State or foreign country)

14. Maiden name **unk.**

15. Birthplace **unk. unk?**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Hazelton**

(b) Address **1201 N. Park, Spfld, Mo.**

17. (a) **removal** (b) Date thereof **Aug 24 1943**  
(City, town, or county) (Month) (Day) (Year)

(c) Place: burial or cremation **Reveries, Mo.**

18. (a) Signature of funeral director **Fred C. Thorne**

(b) Address **1100 Booneville St., Spfld Mo.**

19. (a) **8-24-43** (b) **D. W. Handley**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **23**  
year **43** hour **6** minute **00P.**

21. I hereby certify that I attended the deceased from **Jan 4 1943** to **8-23 1943**  
that I last saw her alive on **8-23 1943**  
and that death occurred on the date and hour stated above.

Immediate cause of death **myocardial infarction** Duration **3 mo.**  
**nephritis** **1 mo**

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)  
(e) Means of injury **D**  
23. Signature **E. Callahan, M.D.** (M. D. for other)  
Address **Spfld, Mo.** Date signed **8-23**

MOTHER FATHER

SEP 20 1943

**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 Fred C. Thier

Licensed Embalmer No. 2841

P. O. Address Springfield

**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.**

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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 10 1943  
State File No. \_\_\_\_\_

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 680

1. PLACE OF DEATH:  
(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 1121 N. Park  
(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 Della 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 Sept 21 1878  
(Month) (Day) (Year)  
8. AGE: Years 66 Months 11 Days 18 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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 \_\_\_\_\_  
(Burial, cremation, or removal) (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 23  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial insufficiency Duration 3 mo.

Due to nephrosis

Due to hypertosis 1 mo

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 E. C. ... (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed 9-18

SUPPLEMENTAL

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

01/15/89

28289