

No. 2
M-5-43
5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27643**

FILED AUG 30 1944

Registration District No. **10**

Primary Registration District No. **2421**

Registrar's No. **16**

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Holcomb, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution most of life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Minnie M^o Elyea

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife none

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

7. Birth date of deceased: Jan 22 1865
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>6</u>	<u>4</u>	<u>—</u> hr. <u>—</u> min.

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

10. Usual occupation Home

MOTHER FATHER

11. Industry or business —

12. Name Thomas Robinson

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

14. Maiden name Minnie Robinson

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

16. (a) Informant Mrs. Dessie Lightfoot

(b) Address Holc.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27 '44 (Month) (Day) (Year)

(c) Place: burial or cremation Shirfield Cem.

18. (a) Signature of funeral director Landers Funeral Home

(b) Address Campbell Mo.

19. (a) 8-20-44 (Date received local registrar) (b) Bernice Wilson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin **35**

(c) City or town Holcomb **5**
(If outside city or town limits, write "RURAL")

(d) Street No. — (If rural, give location)

(e) Citizen of foreign country? yes (Yes or No)

If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
year 1944 hour 2 minute 10 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

Immediate cause of death Malerial Fev **17 day**
Duration

Due to —

Due to Tertian type

Other conditions 28d
(Include pregnancy within 3 months of death)

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? —

23. Signature [Signature] (Specify type of place) — (e) Means of injury

— (M. D. or other)

Address — Date signed —

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

5
0
0

1370

(Licensed Embalmer's Statement on Reverse Side)

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 Christina M. Lander

Licensed Embalmer No. 4227

P. O. Address Campbell, 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.