

S. No. 2
DM-5-43
v. 5-17-39
X38677

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 18 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **229862**
Registrar's No. **7694**

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Barnes Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 0 (Specify whether years, months or days)

In this community _____

3. (a) PRINT FULL NAME Nell J. Robertson

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 John C. Robertson **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased. March 13 1877
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>67</u>	<u>5</u>	<u>19</u>	hr. _____ min. _____

9. Birthplace Franklin County Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name William Pitchford

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

14. Maiden name Rhoda Manion

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

16. (a) Informant Glenda Robertson

(b) Address 4432 Washington Blvd.

17. (a) Removal Removal **(b) Date thereof** 9-4-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Frankfort, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) SEP 6 1944 **(b)** [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Franklin
 (c) City or town West Frankfort
(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 Sept. day 2
 year 1944 hour 7:00 30 P. 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 Intertarsal fracture of left femur. Colles fracture left wrist. Cardiac decompensation
 Duration _____
 Due to _____
 Due to Home at 4432 Washington Ave Aug. 29th 1944. About 2:00 Am.
 Other conditions 1946
(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) Accident
 (b) Date of occurrence Aug 29th 1944
 (c) Where did injury occur? St. Louis
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
(Specify type of place)
 While at work? no **(e) Means of injury** fall

23. Signature [Signature] (M. D. or other)
Address [Signature] **Date signed** 9/1/44

684

1692

1692

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 W. Wilkerson

Licensed Embalmer No. 3575

P. O. Address.....

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.