

S. No. 2  
M-8-43  
5-17-39  
PI X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40566

State File No. 19

Registrar's No. 19

FILED JAN 15 1945  
Registration District No. 3/

Primary Registration District No. 5050

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

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

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Barry  
(c) City or town Mineral Springs  
(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 Martha Jane Robertson  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 27  
year 1944 hour 10 minute A.M.

4. Sex female 5. Color or race white  
6. (a) Single, widowed, married, divorced Widowed  
(b) Name of husband or wife \_\_\_\_\_ (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 24 to Sept 20 1944  
that I last saw her alive on Sept 20 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
97 5 28 \_\_\_\_\_ hr. \_\_\_\_\_ min.

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

10. Usual occupation Housewife

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

MOTHER, FATHER {  
12. Name unknown  
13. Birthplace unknown (City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clarence Moore

(b) Address Cassville, Missouri

17. (a) Burial (b) Date thereof Sept 29 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Jay, Oklahoma

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

(b) Address Cassville, Missouri

19. (a) 12/24/44 (b) Del Williams  
(Date received local registrar) (Registrar's signature)

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) Means of injury \_\_\_\_\_

23. Signature Herbert H. Salyer (M. D. or other) M.D.

Address Cassville Mo Date signed Oct 10

1016

(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 *Margaret Culver*.....

Licensed Embalmer No. *4389*.....

P. O. Address *Cassville*.....

**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.**