

FILED DEC 30 1944

Registration District No. 9

Primary Registration District No. 5094

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Bates
(b) City or town Rich Hill Route 3
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home - Route 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community Life (17 yrs)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates
(c) City or town Rich Hill R.F.D. #2
(If outside city or town limits, write "RURAL")
(d) Street No. 3 W. St. Rockhill Mo.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Orville Leroy Robbins

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race W
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife Margaret (Fritz) O
6. (c) Age of husband or wife if alive 17 years
7. Birth date of deceased 9th Feb 9-1927
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>17</u>	<u>9</u>	<u>27</u>	hr. _____ min. _____

9. Birthplace Bates County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Trucker

11. Industry or business

MOTHER FATHER
12. Name Clyde Wm Robbins
13. Birthplace Bates County Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Mary Susan Ritchie
15. Birthplace Verdun County, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mother
(b) Address R.F.D. Rich Hill
17. (a) Cremation (b) Date thereof Dec. 10 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Springfield
18. (a) Signature of funeral director Booth
(b) Address Rich Hill Mo
19. (a) Dec 9 1944 (b) Mrs. Edna Douglas
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 6
year 1944 hour 7.0 minute _____ M.

21. I hereby certify that I attended the deceased from Oct. 23 1944 to Nov. 30 1944
that I last saw him alive on Nov. 30 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Haematoma Brain

Due to _____
Due to Skull fracture

Other conditions (Include pregnancy within 3 months of death) _____
ADDITIONAL SUPPLEMENTARY PHYSICIAN
Major findings: Of operations _____ INFORMATION REQUESTED
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Oct 23, 1944
(b) Date of occurrence Oct 23 - 1944
(c) Where did injury occur? Rich Hill Bates Mo
(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 C.W. Luter M.D. or other _____
Address Butler Mo Date signed Dec 9 1944

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

2
43
39
95697

JUL 10 1947

RECEIVED

Officer No. 7;

Call No. 11-44-1419

Date Filed 12-18-47

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 *John D. Underwood*
Licensed Embalmer No. *3585*
P. O. Address *Butler MD*

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.

Registration District No. 25

Primary Registration District No. 5094

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Bates
 (b) City or town Osage Imp Rural
(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 _____
years, months or days

3. (a) PRINT FULL NAME D. Wille, J. Roblin
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex m 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 Feb 9
(Month) (Day) (Year)
 8. AGE: Years 17 Months 9 Days _____
If less than one day _____ min.

9. Birthplace _____
(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 Dec Year 1944 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
 that I last saw him _____ alive on _____ 19____
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration

Due to _____ 1952

Due to _____

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) Accident

(b) Date of occurrence Oct 23 - 1944

(c) Where did injury occur? at home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Filling Station
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Carter H. Butler (M. D. or other) MD

Address Butler, Mo. Date signed _____

SUPPLEMENTARY

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

1944
S-40591