S. No. 2
M—8-43
5-17-39
I X37623

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 28 1945

Registration District No. 11

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8914

Primary Registration District No. 5040

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Barry

(b) City or town Rural Exeter Twp.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry 5

(c) City or town Rural 0
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Martha Minerva Roblyer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female /

5. Color or race White

6. (a) Single, widowed, married, divorced Widow 9

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 6 (Day) 1856 (Year)

8. AGE: Years 88 | Months 10 | Days 18 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name John J. Lennon
13. Birthplace Indiana (City, town, or county) (State or foreign country) /

MOTHER
14. Maiden name Rebecca Jerkes
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Will Roblyer
(b) Address Wayne, Missouri,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Maplewood cemeterye

18. (a) Signature of funeral director Culver Funeral Home
(b) Address Cassville, Missouri

19. (a) Mar 6-1945 (Date received local registrar) (b) Grace Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 24th year 1945 hour 1 minute A. M.

21. I hereby certify that I attended the deceased from Feb. 28, 1933, to Feb. 22, 1945 that I last saw her alive on Feb. 22, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic myocarditis	15 years
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

93d

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature E. E. McDaniel (M. D. or other) MDO

Address Cassville, Mo Date signed 3/3/45

1077

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 345-364
Date Filed MAR 23 1945

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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 11 Primary Registration District No. 5040 Registrar's No. 12

1. PLACE OF DEATH:

(a) County Barry

(b) City or town Rural, Exeter Twp.
(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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Martha M. Roblyer

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 W

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 6 (Day) 1857 (Year)

8. AGE: Years 88 Months 10 Days 28 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business none

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) June 9-1945 (Date received local registrar) (b) Grace Williamson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February 24 year 1945 hour minute 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 — Duration

Due to

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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

8914