

FILED MAR 30 1945  
128

Registration District No. ....

Primary Registration District No. 5466

Registrar's No. 215

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

1. PLACE OF DEATH: **GREENE**  
 (a) County  
 (b) City or town: **RURAL, S. Campbell Twp.**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**600 (CHEROKEE) Route #3.**  
 (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: **MO.** (b) County: **GREENE**  
 (c) City or town: **Rural - SPRINGFIELD S. Campbell Twp.**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No: **(600 CHEROKEE) Route #3.**  
 (If rural, give location)  
 (e) Citizen of foreign country? **No.** (Yes or No)  
 If yes, name country.

3. (a) PRINT FULL NAME: **LOUISE ROBB**  
 3. (b) If veteran, name war: **NONE**  
 3. (c) Social Security No.: **NONE**

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **MAR.** day **14**  
 year **1945** hour **11** minute **35** A.M.

4. Sex: **FEMALE** 5. Color or race: **WHITE**  
 6. (a) Single, widowed, married, divorced: **MARRIED**  
 6. (b) Name of husband or wife: **LESTER ROBB**  
 6. (c) Age of husband or wife if alive: **41** years  
 7. Birth date of deceased: **Feb. 10, 1904**  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Apr. 1944** to **March 14, 1945**  
 that I last saw her alive on **3-12-45** and that death occurred on the date and hour stated above.

8. AGE: Years **41** Months **1** Days **4**  
 If less than one day hr. min.

Immediate cause of death: **Adeno Carcinoma of Colon**  
 Duration **1 yr**

9. Birthplace: **FRESNO CALIF.**  
 (City, town, or county) (State or foreign country)

Due to: **468**  
 Due to:  
 Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation: **HOUSE WIFE**  
 11. Industry or business: **AT HOME**

Major findings: **Ca. of Coln**  
 Of operations:  
 Of autopsy:  
 PHYSICIAN: Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name: **DR. E. C. CHAPPEL**  
 13. Birthplace: **UNK. MO.**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name: **SUSAN MAE WILSON**  
 15. Birthplace: **UNK. PA.**  
 (City, town, or county) (State or foreign country)

16. (a) Informant: **Dr. Lester Robb**  
 (b) Address: **600 Cherokee Springfield, Mo.**  
 17. (a) **Funeral** (b) Date thereof: **Mar. 17, 1945**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation: **Maple Park Cem**  
 18. (a) Signature of funeral director: **J. W. Klingner & Co.**  
 (b) Address: **Springfield, Mo.**  
 19. (a) **3-16-45** (b) **S. W. Handley**  
 (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) (e) Means of injury  
 23. Signature: **[Signature]** (M. D. or other)  
 Address: **Springfield, Mo** Date signed: **3-17-45**

JAN 23 1947

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

*Ogle Stone Jr.*

Licensed Embalmer No.

*4976*

P. O. Address

*Springfield 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.