

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1292

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 486

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Wagon Mtn
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Wagon Mtn Hospital # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution over 4 mos 26 days
(Specify whether years, months or days)

In this community yes (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Winnemucco

(c) City or town Rural #1
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Nellie M. Robinson

3. (b) If veteran, name war nil

3. (c) Social Security No. nil

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife not given

(c) Age of husband or wife if alive years

7. Birth date of deceased: June 11 1866
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>10</u>	<u>3</u>	hr. min.

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

10. Usual occupation house wife

11. Industry or business at home

12. Name not given

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

14. Maiden name Clouse

15. Birthplace Mo of Jan
(City, town, or county) (State or foreign country)

16. (a) Informant Maggie Byers

(b) Address Wagon Mtn

17. (a) Burial Wagon Mtn
(Burial, cremation, or removal)

(b) Date thereof 4-15-45
(Month) (Day) (Year)

(c) Place: burial or cremation Oklahoma City, Okla

18. (a) Signature of funeral director Clark Mortuary

(b) Address 5025 King Highway

19. (a) 4-17-45 (b) Edwin J. Eckel
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4/14 day 3
year 1945 hour 3 minute 0 M.

21. I hereby certify that I attended the deceased from Jan 1 at 1945 to 4/14 at 1945
that I last saw her alive on 4/14 at 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage of the brain Duration suddenly
Cerebral arteriosclerosis Duration 1 few years

Due to 1 few years

Due to

Other conditions 1
(Include pregnancy within 3 months of death)

Major findings: 1
Of operations 1

Of autopsy 1

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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? 0 (Specify type of place)

(e) Means of injury 0

23. Signature O. G. Cassius (M. D. or other)

Address Wagon Hospital # 2 Date signed 4/15/1945

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

MOTHER FATHER

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 *Embalmer*.....

Licensed Embalmer No. 4738.....

P. O. Address *St. Joseph, 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.