

FILED SEP 12 1945

Registration District No. _____

Primary Registration District No. 2000

Registrar's No. 648

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town SPRINGFIELD MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1678 W. CALHOUN ST. 1
(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 Red Top
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. # 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME DOSIA ETHEL' ROBERTSON

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ABE F. ROBERTSON 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased APRIL 25, 1883
(Month) (Day) (Year)

8. AGE: Years 62 Months 3 Days 22 If less than one day hr. _____ min. _____

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

10. Usual occupation House Wife

11. Industry or business at Home

12. Name Andrew marion M. Murray

13. Birthplace GREENE Co. MO. 11
(City, town, or county) (State or foreign country)

14. Maiden name Andrew Lewis

15. Birthplace GREENE Co. MO. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Abe F. Robertson

(b) Address Red Top (R#2) MO.

17. (a) Burial (b) Date thereof Aug 24, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cem. J.W. Klingner & Co

18. (a) Signature of funeral director J.W. Klingner MO.
(b) Address SPRINGFIELD MO.

19. (a) 8-22-45 (b) Dr W. S. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG. day 17
year 1945 hour 2 minute 15 A. M.

21. I hereby certify that I attended the deceased from July 20, 1945 to Aug 14, 1945
that I last saw her alive on Aug 16, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Duration 1 month

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations (Signature)

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? _____

While at work? _____ (Specify type of place) (e) Means of injury 0

23. Signature J.B. Bruton (M. D. or other) M.D.

Address Springfield, Mo. Date signed 8/17/45

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

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 Roy A. Lavin
Licensed Embalmer No. 1763
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.

X