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DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS  
**FILED OCT 18 1945 STANDARD CERTIFICATE OF DEATH**

State File No. **34868**  
Registrar's No. **4**

Registration District No. **349** Primary Registration District No. **6185**

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

**1. PLACE OF DEATH:**  
(a) County Sullivan  
(b) City or town Rural - Union Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: near Green City!  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community Life years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Mo. (b) County Sullivan <sup>105</sup>  
(c) City or town Rural <sup>0</sup>  
(If outside city or town limits, write "RURAL")  
(d) Street No. near Green City <sup>0</sup>  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** ISABELLE ROBERTSON  
3. (b) If veteran, name war no 3. (c) Social Security No. 6

**MEDICAL CERTIFICATION**  
20. **DATE OF DEATH:** Month 9 day 24 year 1945 hour 12 minute 30 P.M.  
21. I hereby certify that I attended the deceased from 9-1 to 9-24, 1945, that I last saw her ER alive on 9-23-45, and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Jesse Robertson 6. (c) Age of husband or wife if alive 7 years  
7. Birth date of deceased Jan 11 1863  
(Month) (Day) (Year)

Immediate cause of death Myocarditic HEART FAILURE  
Due to Pulmonary

**8. AGE:** Years 82 Months 8 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: 1330

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Marshall Patrom

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

14. Maiden name Sarah Holt

15. Birthplace N.Y.  
(City, town, or county) (State or foreign country)

16. (a) Informant W.F. Robertson  
(b) Address Green City, Mo.

17. (a) Burial (b) Date thereof 9-26-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springer Cem.  
18. (a) Signature of funeral director Glen E. Ferguson  
(b) Address Green City, Mo.  
19. (a) 10-2-1945 (b) Laura M. Shaw  
(Date received local registrar) (Registrar's signature)

Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

**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) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature J. H. Schuro (M. D. or other) \_\_\_\_\_  
Address Green City, Mo. Date signed 9-24-45

MOTHER FATHER

Duration 7 yrs

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

1351

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
District Health Officer No: 10  
District File Number 10-45-1595  
Date Filed OCT-1-7-1945

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 Archie W Wade

Licensed Embalmer No. 3037

P. O. Address Green City, 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.