

No. 1
1-4-41
17-39
X28390

FILED FEB 7 1948
Registration District No. 238

Primary Registration District No. 5821

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

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Rural, R 3 - Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home - Big P. am
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 10 months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Rural R 3 Sikeston
(If outside city or town limits, write "RURAL")
(d) Street No. R 3
(If rural, give location)
(e) Citizen of foreign country? Sikeston (Yes or No)
If yes, name country No.

3. (a) PRINT FULL NAME Millie Robinson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race Colored
6. (a) Single, widowed, married, divorced unk
6. (b) Name of husband or wife Bob Robinson
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 22 1893
(Month) (Day) (Year)

8. AGE: Years 53 Months _____ Days 9 If less than one day hr. _____ min. _____

9. Birthplace Cortez Ark Tenn
(City, town, or county) (State or foreign country)

10. Usual occupation house wife

11. Industry or business house wife

12. Name Mr Stegson

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

14. Maiden name unknown

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

16. (a) Informant Robinson

(b) Address Sikeston, Mo. R. 4. 19.

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director G. Smith

(b) Address 1212 Main St. Sikeston, Mo.

19. (a) 1-31-46 (Date received local registrar) (b) Helius Louis Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25
year 1946 hour 4 minute _____ a.m.
21. I hereby certify that I attended the deceased from 1-22 1946 to 1-25 1946
that I last saw he alive on 1-22 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Indo Carditis
Duration _____

Due to _____
Due to _____

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

Major findings: Of operations 928
Of autopsy _____
PHYSICIAN _____

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? _____

23. Signatures: _____ (Specify type of place) _____ (M. D. or other)
Address 109 N. Liberty St. Sikeston, Mo. Date signed 1-26-46

RECEIVED

District Health Office No. 2,

District File Number 246-159

Date Filed 2-5-46

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 Fred J. Smith

Licensed Embalmer No. 4408

P. O. Address 104 Petty St. Detroit

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb
Registrar's No. 127

Registration District No. 238 Primary Registration District No. 5-824

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Rural Big Prairie 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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Wilke Robinson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced (unk)

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Jan 22
(Month) (Day) (Year)

8. AGE: Years 53 Months _____ Days _____ If less than one day hr. _____ min. _____

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

MOTHER FATHER

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3460