

No. 2
4-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17343

Registration District No. 20 Primary Registration District No. 5735 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Macon
(b) City or town rural Jackson
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Macon 61
(c) City or town rural
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joseph P. Robertson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 24
year 1946 hour 11 minutes 06 P.M.
21. I hereby certify that I attended the deceased from April 22, 1946, to April 24, 1946
that I last saw him alive on April 24, 1946
and that death occurred on the date and hour stated above.

4. Sex M.O. 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Imma B. Robertson 6. (c) Age of husband or wife if alive 38 years
7. Birth date of deceased Oct. 13 - 1869
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage
Duration _____
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

8. AGE: Years 76 Months 6 Days 11 If less than one day hr. _____ min. _____
9. Birthplace Rolla Co. Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Minister & Farmer

Major findings: Of operations _____
Of autopsy Brain
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
11. Industry or Business _____
12. Name James E. Robertson
13. Birthplace Mo. (City, town, or county) (State or foreign country)
14. Maiden name Maria L. Glasscock
15. Birthplace Mo. (City, town, or county) (State or foreign country)
16. (a) Informant Mr. Imma B. Robertson
(b) Address Atlanta Mo. R.1
17. (a) Burial (b) Date thereof 4-26-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Labor Cem. Macon
18. (a) Signature of funeral director Stephen & Sordung
(b) Address Macon Mo.
19. (a) 5-1-46 (b) Miss C. P. Crygier
(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? _____
(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature G. L. Ryde (M. D. or other) _____
Address Atlanta Missouri Date signed 5-1-46

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

RECEIVED

District Health Officer No. 10

District No. Number 5-46-1092

Date Filed MAY 23 1946

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.....

C. L. Stephens

Licensed Embalmer No. 3057

P. O. Address.....

Macon, 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.