

S. No. 2-
M-5-43
7-5-17-39
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DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED SEP 23 1946 STANDARD CERTIFICATE OF DEATH

State File No. **29666**
Registrar's No. **1050**

Registration District No. **42** Primary Registration District No. **5125**

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

1. PLACE OF DEATH:
(a) County **Buchanan** Center Township
(b) City or town **Rural Center Township, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2 miles S. of St. Joseph, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **Life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Buchanan**
(c) City or town **Rural "CENTER TWSP"**
(If outside city or town limits, write "RURAL")
(d) Street No. **R.R. #6, St. Joseph, Mo.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mábel Robertson**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**
4. Sex **Female** 5. Color of race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Charles E. Robertson** 6. (c) Age of husband or wife if alive **71** years
7. Birth date of deceased **May 8 1885**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept.** day **16** year **1946** hour **10** minute **25 P** M.
21. I hereby certify that I attended the deceased from **1-3-44** to **9-16-46** that I last saw **her** alive on **Sept 14** and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
61 4 8 hr. min.

Immediate cause of death **Heart thrombosis arteriosclerosis** Duration **2 yrs**
Due to _____
Due to _____

9. Birthplace **Buchanan County Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **At Home**
11. Industry or business **At Home**

Other conditions **Arterial hypertension** 1 with
(Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy **none** **A2P**

MOTHER FATHER
12. Name **Levi Lewelling**
13. Birthplace **Unknown** **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Anna Marlow**
15. Birthplace **Unknown** **Unknown**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Charles E. Robertson**
(b) Address **R.R. #6, St. Joseph, Mo.**
17. (a) **Burial** (b) Date thereof **9/19/46**
(Burial, cremation, or removal) (City, town, or county) (Month) (Day) (Year)
(c) Place: burial or cremation **King Hill Cemetery**
18. (a) Signature of funeral director **Horton R. Job + Burman**
(b) Address **St. Joseph, Mo.**
19. (a) **Sept. 20, 1946** (b) **[Signature]**
(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?
While at work? _____ (Specify kind of place) Means of injury _____
23. Signature **[Signature]** (M. D. or other) **[Signature]**
Address _____ Date signed **9-17-46**

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~~.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Eugene Wood*

Licensed Embalmer No. *3804*

P. O. Address *315 So. 10th 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.