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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 31 1946
Registration District No. 240

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 5827

State File No. 41467
Registrar's No. 35

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

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Rural Lewis Twsp.
(c) Name of hospital or institution:
Home.
(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)

3. (a) PRINT FULL NAME Georgia Lueen Robinson.
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 Single.
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased June 15 1945.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 6 9 hr. _____ min.

9. Birthplace Lilbourn, Missouri. (1)
(City, town, or county) (State or foreign country)
10. Usual occupation Child.

11. Industry or business _____
12. Name Shirley Robinson
13. Birthplace Lilbourn, Missouri. (1)
(City, town, or county) (State or foreign country)
14. Maiden name Ora Lueen Wheeler.
15. Birthplace Kentucky.
(City, town, or county) (State or foreign country)

16. (a) Informant Shirley Robinson.
(b) Address Lilbourn, Missouri.
17. (a) Burial (b) Date thereof 12-27-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mounds Park Cem.
18. (a) Signature of funeral director Ponder Funeral Home.
(b) Address Lilbourn, Missouri.
19. (a) 12-26-46 (b) H. L. Ponder Deputy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid 72
(c) City or town Rural Lewis Twsp. 9
(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 December day 24
year 1946 hour 2 minute 30 P. M.
21. I hereby certify that I attended the deceased from _____
_____, 19____ to _____, 19____;
(that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Pneumonia of Left Lung
Middle Lobe, Cause
Due to of Right Lung.
Due to Enlarge Thyroid
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy yes 108
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 _____
23. Signature H. L. Ponder Deputy (34. Doctor or other) Cerner 3
Address New Madrid, Mo. Date signed 12/26-46

JAN 2 1947

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 Homer L Ponder

Licensed Embalmer No. 3367

P. O. Address. Filboine, 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.