

No. 2  
2-43  
17-30  
X35897

**FILED FEB 20 1947**

Registration District No. 100

Primary Registration District No. 5392

Registrar's No. 10

1. PLACE OF DEATH:

(a) County DENT  
 (b) City or town RURAL WATKINS TWP  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: NONE  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DENT **33**  
 (c) City or town RURAL **7**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. NEAR SALEM, MO  
(If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME NANCY JANE ROBNETT

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

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced. W 2  
 6. (b) Name of husband or wife JOHN DAVID ROBNETT 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased MARCH 15 1869  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
77 10 22 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation AT HOME

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

MOTHER FATHER

12. Name PATRICK HAMILTON M  
 13. Birthplace NO RECORD  
(City, town, or county) (State or foreign country)  
 14. Maiden name MARY WILSON  
 15. Birthplace NO RECORD  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Robnett  
 (b) Address SALEM, MISSOURI  
 17. (a) BURIAL (b) Date thereof 2-11-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation FAIR PLAY, MO.

18. (a) Signature of funeral director W. T. Spencer  
 (b) Address SALEM, MISSOURI  
 19. (a) 2-8-47 (b) m. m. Hart  
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 7  
 year 1947 hour 5:00 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Jan 12 1946 to Feb 6 1947;  
 that I last saw h. aw alive on Feb 3 1947;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
Lebar  
 Due to influenza

Due to D

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_ 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) (c) Means of injury 0  
 23. Signature W. T. Spencer (M. D. or other) \_\_\_\_\_  
 Address SALEM, MO Date signed \_\_\_\_\_

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

RECEIVED

District No. 5,

District File Number 24776

Date Filed 2-28-47

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, ~~only~~.....

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

Signed Wm. W. McRae

Licensed Embalmer No. 3806

P. O. Address. Salem, 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.

Registration District No. 100

Primary Registration District No. 5392

Registrar's No. 10

1. PLACE OF DEATH:

(a) County De Witt  
(b) City or town Rural  
(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 \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Nancy J. Robnett

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

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

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

7. Birth date of deceased mar (Month) 13 (Day) 1862 (Year)

8. AGE: Years 77 Months 10 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 28-47 (Date received local registrar) (b) M. M. Hart, M.D. (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 \_\_\_\_\_ Day \_\_\_\_\_  
year 1947 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) \_\_\_\_\_

Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-4450