

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4623**
Registration District No. **137**
Primary Registration District No. **4208**
Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Harrison**
(b) City or town **Cainsville**
(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 **All Life** years, months or days) _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Harrison**
(c) City or town **Cainsville**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Frona Elizabeth Robertson**
3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**
4. Sex **Female** 5. Color or race **White**
6. (g) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased **April 26 1869**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **January** day **31st.**
year **1947** hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from **Jan 10**
1947 to **Jan 21** 19**47**
that I last saw h. **or** alive on **Jan 26** 19**47**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
77 **9** **5** hr. _____ min.

Immediate cause of death **Cardiac Hypertrophy** Duration
Had 17 yrs. Pneumonia several years Duration
Due to **Jan 10**

9. Birthplace **Mercer County Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housekeeper**

Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name **Julius G. Mullins**
13. Birthplace **Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Jane Alexander**
15. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.
108

16. (a) Informant **Mable Nelson**
(b) Address **Cainsville, Missouri**
17. (a) **Burial** (b) Date thereof **Feb. 2, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mullins Cemetery**
18. (a) Signature of funeral director **E. J. Stoklasa**
(b) Address **Cainsville, Mo.**
19. (a) **2-10-1947** (b) **S. Pha Shaw**
(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 type of place) Means of injury _____
23. Signature **S. P. Shaw** (M. D. or other) _____
Address **Cainsville, Missouri** Date signed **2/1/47**

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

STATEMENT BY LICENSED EMBALMER

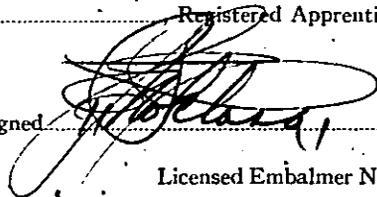
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me; of / by

Eddie J. Stoklasa

Registered Apprentice No.

working under my personal supervision.

Signed



Licensed Embalmer No. 3602

P. O. Address: Cainsville, Missouri.

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.