

DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC HEALTH
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 49

1. PLACE OF DEATH:

(a) County Cooper
(b) City or town Boonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 904 Sisk St. 3
(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 Mo. (b) County Howard 45
(c) City or town New Franklin Mo. 3
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SOPHIA MARISSA ROBERTSON

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife Doc 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 27 1868
(Month) (Day) (Year)

8. AGE: Years 78 Months 11 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Howard Co Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Thomas Jordan

13. Birthplace Howard Co Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Martha Estes

15. Birthplace Va.
(City, town, or county) (State or foreign country)

16. (a) Informant Sylvanus Robertson

(b) Address New Franklin Mo.

17. (a) Removal (b) Date thereof 3/24/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clark Chapel

18. (a) Signature of funeral director C. S. Newsum

(b) Address New Franklin Mo.

19. (a) 3-30-47 (b) D. Cooper
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24
year 1947 hour 3 minute 20 a.m.

21. I hereby certify that I attended the deceased from Jan 24, 1947, to Mar 24, 1947
that I last saw her alive on Mar 19, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: myocarditis with congestive heart failure

Due to _____

Due to _____

Other conditions: Fibro-myomatosis of uterus
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

Duration

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) Means of injury _____

23. Signature T. C. Beckett, M.D.
Address Boonville, Mo. Date signed 3/24/47

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 4-11-47.....

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, or by.....

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

Signed W. L. Hall.....

Licensed Embalmer No. 3515.....

P. O. Address New Franklin, 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.