

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16137**
Registrar's No. **28**

Registration District No. **337**

Primary Registration District No. **6138**

1. PLACE OF DEATH:

(a) County Shelby county
(b) City or town Bethel Mo. Rural
(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 None
(Specify whether
In this community Seventy years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby / 02
(c) City or town Bethel Rural 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. 0
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6th
year 1947 hour 10 minute 15 A. M.
21. I hereby certify that I attended the deceased from March 6
1947 to March 6, 1947
that I last saw him alive on March 6
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion
Duration one hour

Due to _____
Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: 94A
Of operations _____
Of autopsy _____

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 S.P. Simpson (M. D. or other) 105
Address Duenna Mo Date signed 3-28-47

3. (a) PRINT FULL NAME Sarah Jane Robertson

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

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

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

7. Birth date of deceased October 25th 1859
(Month) (Day) (Year)

8. AGE: Years 87 Months 4 Days 10
If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Jack King

13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Ruth Rankins

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

16. (a) Informant Benjamin Robertson

(b) Address Shelbyville, Mo.

17. (a) Burial (b) Date thereof 3-7-1947
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Presant Prairie

18. (a) Signature of funeral director Million & Barkleew
Shelbina Mo.

(b) Address _____

19. (a) April 2-47 (b) Ruth Jaeger
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

22

1513

1947

RECEIVED
District Health Officer No. 10
District File Number 447-212
Date Filed APR 15 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.....

James D. Davis

Registered Apprentice No. *443*

working under my personal supervision.

Signed..... *W. Hawkins*

Licensed Embalmer No. *3498*

P. O. Address..... *Albina 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.

copy of record (H.S.)