

Registration District No. **278**

Primary Registration District No. **5953**

1. PLACE OF DEATH
 (a) County **Pike**
 (b) City or town **Rural, Buffalo**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
RFD. # I Louisiana, Missouri
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether
 In this community **2yrs.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Pike**
 (c) City or town **Rural**
(If outside city or town limits, write "RURAL")
 (d) Street No. **RFD. # I Louisiana**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country **--**

3. (a) PRINT FULL NAME **Bertha Robbins**
 3. (b) If veteran, name war **No.**
 3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Sylvester Robbins**
 6. (c) Age of husband or wife if alive **56** years
 7. Birth date of deceased **April 8, 1882**
(Month) (Day) (Year)

8. AGE: Years **65** Months **I** Days **I7**
If less than one day hr. min.

9. Birthplace **Monroe Co., Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Hswfe.**

11. Industry or business **Own Home**

MOTHER FATHER {
 12. Name **Thomas Wilcox**
 13. Birthplace **? New York**
(City, town, or county) (State or foreign country)
 14. Maiden name **Delliah Neer**
 15. Birthplace **Canada**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Sylvester Robbins**

(b) Address **RFD. # I, Louisiana, Mo.**

17. (a) **Burial** (b) Date thereof **5/27/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Riverview Cem.**

18. (a) Signature of funeral director **Haley Mortuary**

(b) Address **Louisiana, Missouri**

19. (a) **5/26/47** (b) **Bernice Collier**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **25**
 year **1947** hour **12:01** minute **A.M.** M.
 21. I hereby certify that I attended the deceased from **APRIL**
 1947, to **MAY 25**, 1947,
 that I last saw her alive on **APRIL**, 1947,
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
ACUTE MYOCARDIAL FAILURE
ACUTE PULMONARY EDEMA.

Other conditions (Include pregnancy within 3 months of death)

Major findings:
 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?
(Specify type of place)

While at work?.....
 (Specify type of place) (e) Means of injury.....

23. Signature **Paul L. Trayer** (M. D. or other) **MD**
 Address **Louisiana, Missouri** Date signed **5/26/47**

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

RECEIVED
District Health Officer No. 10
District File Number 6-47-943
Date FEB. JUN. - 3 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, ~~XXXX~~.....

XXXXXXXXXXXXXXXXXX

working under my personal supervision.

Signed George O. Wagner.....

Licensed Embalmer No. 3773.....

P. O. Address Louisiana, 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.