

FILED OCT 17 1947

Registration District No. 222

Primary Registration District No. 1333

Registrar's No.

1. PLACE OF DEATH:

(a) County Moniteau  
(b) City or town Clarksburg  
(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. 17 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Moniteau  
(c) City or town Clarksburg  
(If outside city or town limits, write "RURAL")  
(d) Street No. None  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country Native

3. (a) PRINT FULL NAME Charles Aubrey Robertson

3. (b) If veteran, name war None 3. (c) Social Security No. 493-03-4292

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

6. (b) Name of husband or wife Lelia Robertson 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased March, 5th, 1893  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
54 7 0 hr. min.

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

10. Usual occupation Spreader

11. Industry or business A.F. Martin Mfg. Co

12. Name William Robertson

13. Birthplace Moniteau County, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Mildred Kelsey

15. Birthplace Moniteau County, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant J.E. Robertson (son)

(b) Address Clarksburg, Mo.

17. (a) Burial (b) Date thereof 10/6/47  
(Month) (Day) (Year)

(c) Place: burial or cremation Clarksburg, Masonia, Clarksburg, Mo.

18. (c) Signature of funeral director James E. Richard

(b) Address Tipton, Mo.

19. (a) 10-7-47 (b) Bridie Stinger  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 5th year 1947 hour 5 minute 25 P. M.

21. I hereby certify that I attended the deceased from Aug 22 1947 to Oct 5 1947; that I last saw him alive on Oct 2 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Gelatinous Adenocarcinoma of abdomen. Nodules everywhere.

Duration 6 mos

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations As above Operation June 30 1947 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) (e) Means of injury

23. Signature Edgar A. Kibbe (M. D.) Address California Date signed 10/6/47

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed OCT 16 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 \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed *Jessie E. Richardson*  
Licensed Embalmer No. *3466*  
P. O. Address *Lipton Md*

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. 222 Primary Registration District No. 4333

1. PLACE OF DEATH: Moniteau  
(a) County Moniteau  
(b) City or town Clarksburg  
(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 Charles A. Robertson  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased March (Month) 1947 (Year)

8. AGE: Years 54 Months \_\_\_\_\_ Days \_\_\_\_\_ (Less than one day) hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 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) 10-7-47 (Date received local registrar) (b) Birdie Sturgis (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 \_\_\_\_\_ year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 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) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

