

No. 2
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5-17-30
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 7 1948

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35500

Registration District No. 4

Primary Registration District No. 5024

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Atchison
(b) City or town Rural, Polk
(If outside city or town limits, write "RURAL" and name of township)
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison
(c) City or town Rural - Polk Twsp.
(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 _____

3. (a) PRINT FULL NAME Wm. H. Robinette

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Nora Harmon 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: 9 (Month) 9 (Day) 1862 (Year)

8. AGE: Years Months Days If less than one day
86 2 13 hr. 0 min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Rufus Robinette
13. Birthplace Unknown Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Mary Dracy
15. Birthplace Unknown Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Cathel Moore

(b) Address Watson Mo.

17. (a) Burial (b) Date thereof 9/26/1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation High Creek Cem.

18. (a) Signature of funeral director Bartholomew Mortuary

(b) Address Rock Port, Mo.

19. (a) 11-26-48 (b) Betty Crabtree
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 22,
year 1948 hour 10 minute 30P. M.

21. I hereby certify that I attended the deceased from NOV.
20, 1948, to NOV. 22, 1948
that I last saw him alive on NOV. 20, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral haemorrhage
Duration 9mo.

Due to _____

Due to _____

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

Major findings: 83W
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 G.G. Reuther (M. D. or other) _____

Address Rockport, Mo. Date signed 11/24/48

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, or by.....

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

Signed *Grady Bartholomew*

Licensed Embalmer No. 3173

P. O. Address Rock Port, 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.

Registration District No. 4 Primary Registration District No. 5024

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(b) City or town quail
(If outside city or town limits, write "RURAL" and name of township)
(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 Wm H. Robinetto
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 wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 7 (Month) (Day) (Year)

8. AGE: Years 86 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 11-26-48 (b) Kelly Crabtree
(Date received local registrar) (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 1948 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____
that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

Due to _____
Due to _____
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?
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Date signed _____

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

SUPPLEMENTARY 2

S-35477