

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 300
10.48

FILED FEB 4 1949

REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3056 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howard	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Moberly Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Higbee Mo Rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION McCormick Hospital		d. STREET ADDRESS (If rural, give location) R. F. D. Higbee Mo	
3. NAME OF DECEASED (Type or Print) a. (First) Mattie b. (Middle) C c. (Last) Robb			4. DATE OF DEATH (Month) (Day) (Year) Jan 19 1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 20 1885
9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	
11. BIRTHPLACE (State or foreign country) Howard Co.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Richard Martin		13b. MOTHER'S MAIDEN NAME Martha Creve	
14. NAME OF HUSBAND OR WIFE Estil Robb Higbee Mo		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Estil Robb Higbee Mo ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gangrene of Intestine		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) strangulated Hernia	
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 12-29-48		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 1-19 , 1948, to 1-19 , 1949, that I last saw the deceased alive on 1-19 , 1949, and that death occurred at 4-50A.m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) V. Robinson 2 D.O.		23b. ADDRESS Higbee, Mo	
23c. DATE SIGNED 1-25-49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Jan 21 49		24c. NAME OF CEMETERY OR CREMATORY Sharon	
24d. LOCATION (City, town, or county) (State) R. F. D. Higbee Mo		25. FUNERAL DIRECTOR'S SIGNATURE Burton Funeral Home Higbee Mo ADDRESS	
DATE REC'D BY LOCAL REG. 1-28-49		REGISTRAR'S SIGNATURE Leah Williams	

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

RECEIVED

District Health Officer No. 10

District File Number 2-49-182

Date Filed FEB 2 - 1948

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed

Marion E. Allison

Licensed Embalmer No. 3957

P. O. Address

Woburn, 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.