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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 17 1949

State File No. 9608

BIRTH NO. _____		REG. DIST. NO. 293		PRIMARY REG. DIST. NO. 6015		Registrar's No. 10	
1. PLACE OF DEATH a. COUNTY <u>Randolph</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Huntsville</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) <u>rural Salt Spring</u>		TOWN _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Marion</u> b. (Middle) <u>Robertson</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>3-2-1949</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12/11/1860</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Wash Wacker</u>			13b. MOTHER'S MAIDEN NAME <u>Marion Wacker</u>		14. NAME OF HUSBAND OR WIFE <u>J. R. Robertson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Willard Robertson</u>		ADDRESS <u>Huntsville</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Epi staxis - nose bleed</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4500</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>D.K.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 <u>Mar 2, 1949</u> , to <u>Mar 2, 1949</u> , that I last saw the deceased alive on <u>Mar 2, 1949</u> , and that death occurred at <u>59</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W. J. Dreyer, M.D.</u>				23b. ADDRESS <u>Huntsville Mo</u>		23c. DATE SIGNED <u>3/4/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>March 4/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Eds Chapel</u>		24d. LOCATION (City, town, or county) (State) <u>Huntsville Mo</u>	
DATE REC'D BY LOCAL REG. <u>3-11-49</u>		REGISTRAR'S SIGNATURE <u>Miss V.A. Barnhart</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Wesley Thompson</u>		ADDRESS <u>Huntsville</u>	

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

RECEIVED

District Health Officer No.

District File Number 349

Date Filed MAR 16 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Mr. J. A. Thompson

Signed _____
Student Embalmer

Licensed Embalmer No. 3282

P. O. Address Madison, 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.