S. L. Robinson

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5648

State File No.

BIRTH NO. FILED FEB 17 1954 REG. DIST. NO. 272 PRIMARY REG. DIST. NO. 1397 Registrar's No. 4

1. PLACE OF DEATH
a. COUNTY: Reynolds
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Centerville
c. LENGTH OF STAY (In this place): 8 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Reynolds
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Centerville
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Millie
b. (Middle): Jane
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): 2-8-54

5. SEX: F
6. COLOR OR RACE: Col
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: unknown abt
9. AGE (In years last birthday): 66
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Magnolia Ark
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Newt McElrath
13b. MOTHER'S MAIDEN NAME: Sarah Holder
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Harrison Duncan
ADDRESS: Center Mo

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): died without medical aid - No foul play

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 7955
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 11:55 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: S. L. Robinson (Degree or title): Local Registrar
23b. ADDRESS: Steele Mo
23c. DATE SIGNED: 2/12-54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 2-9-59
24c. NAME OF CEMETERY OR CREMATORY: Holly Grove
24d. LOCATION (City, town, or county) (State): Steele Mo

DATE REC'D BY LOCAL REG.: 2-8-54
REGISTRAR'S SIGNATURE: S. L. Robinson 2-49-0
25. FUNERAL DIRECTOR'S SIGNATURE: Gurman-mdt Co.
ADDRESS: Steele Mo

(Licensed Embalmer's Statement on Reverse Side)

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

2-34-54

PEMISCOT COUNTY HEALTH DEPARTMENT
COURTHOUSE PHONE 79
CARUTHERSVILLE, MO.

FEB 18 1954

FEB 16 1954

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 Not Embalmed working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.