

FILED MAY 17 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **16531**BIRTH NO. _____ REG. DIST. NO. **178** PRIMARY REG. DIST. NO. **4283** Registrar's No. **43**

1. PLACE OF DEATH a. COUNTY Lewis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Lewis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ewing		c. CITY OR TOWN Ewing	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) 0560	
3. NAME OF DECEASED (Type or Print) Elvora JANE Robertson		4. DATE OF DEATH (Month) (Day) (Year) May 16 1954	
5. SEX Female 6. COLOR (R RACE) White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH April 20, 1868		9. AGE (In years last birthday) 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY General	
11. BIRTHPLACE (City and State or Foreign Country) Camp Point Ill		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Joseph Miller		13b. MOTHER'S MAIDEN NAME Elizabeth Keller	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Carlynn Bailey ADDRESS Maywood 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) Intestinal obstruction. ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Probable intestinal malignancy + stroke Eyes Bgo (Years.)	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 5705H	
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)		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 Aug , 1952, to 6 May , 1954, that I last saw the deceased alive on 6 May , 1954, and that death occurred at P.O. m., from the causes and on the date stated above.			
23a. SIGNATURE John W. Willis (Degree or title) D.O. - 2		23b. ADDRESS Lewistown Mo	
23c. DATE SIGNED 11 May 54			
24a. BURIAL CREMATION, REMOVAL (Specify) May 9, 1954		24b. DATE	
24c. NAME OF CEMETERY OR CREMATORY Emerson		24d. LOCATION (City, town, or county) (State) Emerson, Marion Co, Mo	
DATE REC'D BY LOCAL REG. 5-14-54		REGISTRAR'S SIGNATURE P. W. Jennings, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Thomas Ball ADDRESS Ewing, Mo			

(Licensed Embalmer's Statement on Reverse Side)

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

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..

Student.....
Signature of Student Embalmer

Signed..... *Thomas Ball*

Licensed Embalmer No..... *17*

P. O. Address..... *Ewing*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.