

FILED FEB 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3569**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **322** PRIMARY REG. DIST. NO. **6088** Registrar's No. **13**

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Rural-Miami TWP township</b> )	c. LENGTH OF STAY (in this place) <b>2 yrs.</b>	c. CITY OR TOWN <b>Rural-Miami TWP</b>	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>(9 Mi N. W. Marshall, Mo.)</b>		e. STREET ADDRESS (If rural, give location) <b>9 Mi N.W. Marshall, Mo. 0970</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>MARTHA</b>	b. (Middle)	c. (Last) <b>JAMES</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 29, 1955</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Mo. 23, 1873</b>	9. AGE (in years last birthday) <b>81</b>	IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b>	IF UNDER 24 HRS. Hours <b>-</b> Min. <b>-</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John David Robinson</b>	13b. MOTHER'S MAIDEN NAME <b>Nancy Kelly</b>	14. NAME OF HUSBAND OR WIFE <b>-----</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Harvey Rose Malta Bend, Mo.</b>
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary artery disease</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arteriosclerotic heart disease.</b> DUE TO (c) <b>diabetes mellitus.</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>260x</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Jan 29, 1955**, to **29 Jan, 1955**, that I last saw the deceased alive on **29 Jan, 1955**, and that death occurred at **8:25 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Ralph H. Jones M.D.</b>	23b. ADDRESS <b>Marshall, Mo.</b>	23c. DATE SIGNED <b>1-31-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>1-30-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Masonic Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>Pocahontas, Ark.</b>
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DATE REC'D BY LOCAL REG. <b>1-31-55</b>	REGISTRAR'S SIGNATURE <b>Ms. Earl Metz</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Harry Hershberger Marshall, Mo</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

5970 /

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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 Joseph R. Mackler.....

Licensed Embalmer No. 457

P. O. Address Marshall

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.