

FILED JUL 11 1946  
128

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Registration District No. 128 Primary Registration District No. 2000

State File No. \_\_\_\_\_

Registrar's No. 534

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Springfield Baptist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 1/2 wks.  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stone 104  
(c) City or town Crane "Rural"  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 1  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Samuel Tillman Robinson

3. (b) If veteran, name war UNK 3. (c) Social Security No. 497-24-6538

4. Sex male 5. Color or race wht. 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Clara Robinson 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Feb 19, 1886  
(Month) (Day) (Year)

8. AGE: Years 60 Months 4 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace UNK. Tennessee  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name John Calvin Robinson

13. Birthplace UNK. Tenn. 1  
(City, town, or county) (State or foreign country)

14. Maiden name Marcy Collier

15. Birthplace Unknown Unk. 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Byron Robinson

(b) Address Hollister, Mo.

17. (a) Burial (b) Date thereof 6-21-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Masonic Cemetery Crane

18. (a) Signature of funeral director King - Funeral Home

(b) Address HURON, MO.

19. (a) 6-20-46 (b) S. W. Handley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 19 day June  
year 1946 hour 4 minute 35 P. M.

21. I hereby certify that I attended the deceased from May 24, 1946 to June 17, 1946  
that I last saw him alive on June 19, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of stomach Duration 190+  
hemorrhages from

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy UNK

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (Country) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Ray D. Callaway (M. D. or other) M.D.

Address Springfield, Mo. Date signed 6/19/46

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

9  
2  
6

180

MOTHER, FATHER

LV

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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.....

....., Registered Apprentice No. ~~4240~~  
working under my personal supervision.

Signed..... *B. Lynn White*.....

Licensed Embalmer No. *4240*.....

P. O. Address *Anson, 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.

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