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37823

FILED OCT 13 1948

State File No.

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 254

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 22 days
(Specify whether years, months or days)

In this community 22 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Carroll 17

(c) City or town Norborne 2
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 1

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Thomas S. Robinson

3. (b) If veteran, name war _____

3. (c) Social Security No. (111 Mo.)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 7th
year 1948 hour 1:00 minutes _____ P. M.

21. I hereby certify that I attended the deceased from Sept 16, 1948 to 7 Oct., 1948
that I last saw him alive on 7 Oct., 1948
and that death occurred on the date and hour stated above.

4. Sex male 0

5. Color or race White

6. (a) Single, widowed, married, divorced W 11

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 8-11-65
(Month) (Day) (Year)

Immediate cause of death: Arteriosclerotic heart disease Duration 2 yrs

Basal cell Ca. 5 yrs

8. AGE: Years Months Days If less than one day

| | | | |
|----|---|----|----------------------|
| 83 | 1 | 23 | hr. _____ min. _____ |
|----|---|----|----------------------|

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Jaundice 95K

Of autopsy _____

9. Birthplace Breckenridge Co. Ky.
(City, town, or county) (State or foreign country)

10. Usual occupation ex. painter

11. Industry or business _____

MOTHER FATHER

12. Name _____ 9

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____ 7

15. Birthplace _____ (City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

16. (a) Informant State Cancer Hospital

(b) Address Columbia, Mo.

17. (a) Burial (b) Date thereof 10-9-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wesleyan

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) (County) (State)

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

18. (a) Signature of funeral director R. P. Hallett, D.D.S.

(b) Address Columbia, Mo.

19. (a) 10-7-48 (b) Mrs. R. E. Palmer
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Dr. E. Schmitt (M. D. or other)

Address Ellis Fischel Hospital Date signed 7 Oct 48

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed OCT 12 1948

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, ~~only~~.....

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

Signed *Lysman H. Sprinkle*

Licensed Embalmer No. *4013*

P. O. Address. *Columbia, 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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3-45
13880

State File No. Nov.
Registrar's No. 254

Registration District No. 38 Primary Registration District No. 3006

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thomas S Robinson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Aug 14 (Month) (Day) (Year)

8. AGE: Years 83 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____ Duration _____

Arteriosclerotic Cardio-vascular disease
Due to _____

Basal Cell Carcinoma left upper eyelid
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (c) Means of injury _____

23. Signature Thomas S Robinson M.D. (M. D. or other) _____

Address Oliver Mitchell Kap Date signed _____

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

SUPPLEMENTARY

18 Oct. 48

S-28871