

FILED NOV 27 1948

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

39157

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

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 147

1. PLACE OF DEATH:

(a) County Vernon  
(b) City or town Washington Sup. Rural  
(c) Name of hospital or institution: State Hospital #3  
(d) Length of stay: In hospital or institution 1 yr. 1 mo. 6 days  
In this community 1 yr - 1 month - 0 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
Street No. Saint Louis  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

George Robinson

3. (b) If veteran, name war OK

3. (c) Social Security No. OK

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife -

6. (c) Age of husband or wife if 8 alive \_\_\_\_\_ years

7. Birth date of deceased March 10 1874

8. AGE:

Years 74 Months 8 Days 2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace De Sable Mich.

10. Usual occupation none

11. Industry or business

MOTHER FATHER { 12. Name George Robinson  
13. Birthplace Canada  
14. Maiden name Margaret M. Hanna  
15. Birthplace Canada

16. (a) Informant Deceased

(b) Address State Hospital #3

17. (a) Burial (b) Date thereof 11-13-48

(c) Place: burial or cremation Hospital Cemetery

18. (a) Signature of funeral director W. H. Binger

(b) Address Merula, Mo

19. (a) 11-15-48 (b) W. H. Binger

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 10  
year 1948 hour 405 minute P. M.

21. I hereby certify that I attended the deceased from 10-10-47 to 11-10-48  
that I last saw him alive on 11-10-48  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage  
Due to Arteriosclerosis & Hypertension

Due to Lo

Other conditions: 10-10

Major findings: fracture of skull from Fall.

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

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

(a) Accident, suicide, or homicide (specify) Fall

(b) Date of occurrence 11-8-1948

(c) Where did injury occur? State Hospital #3 Vernon Mo

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

While at work? No (e) Means of injury Fall on steps

23. Signature J. B. Bunch (M. D. or other) \_\_\_\_\_

Address State Hospital #3 Date signed 11-10-48

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

RECEIVED

District Health Officer No. 7)

District File No. 10-48-1348

Date Filed 11-23-48

**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 <sup>not</sup>.....

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

Signed Mark C. Eisinger

Licensed Embalmer No. 2656

P. O. Address Nevala, 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, above space should be left blank.