

FILED JUN 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14718**

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>164</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Kirksville</u>		c. LENGTH OF STAY (in this place) <u>7 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kirksville</u>		3 3	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1015 S. Florence St.</u>				d. STREET ADDRESS (If rural, give location) <u>1015 S. Florence St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>EMILY</u>		b. (Middle) <u>KOHLMYER</u>		c. (Last) <u>ROBINSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 31, 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>December 1, 1852</u>	
9. AGE (In years last birthday) <u>96</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>29</u>		IF UNDER 4 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaking</u>		11. BIRTHPLACE (State or foreign country) <u>Princeton, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jacob Karne</u>		13b. MOTHER'S MAIDEN NAME <u>Dellia Strong</u>		14. NAME OF HUSBAND OR WIFE <u>John Robinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Mrs. C. Richard, 1015 S. Florence, Kirksville, Mo.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> *ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardio-vascular-renal disease - Glomerulonephritis.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>_____</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>several years.</u> <u>11/2 2X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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 <u>July 12, 1945</u> , to <u>May 31, 1949</u> , that I last saw the deceased alive on <u>May 31, 1949</u> , and that death occurred at <u>12:15 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Howard E. Gross, D.O.</u>		23b. ADDRESS <u>2 Kirksville, Mo.</u>		23c. DATE SIGNED <u>6-2-49.</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6-2-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Shaffer Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Near Millard, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>6-4-49</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Davis Funeral Home Kirksville, Mo.</u>			

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

RECEIVED

District Health Officer No.

District File Number 6-411

Date Filed JUN 8 1949

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

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Clarence M. Billo

Licensed Embalmer No. 4375

P. O. Address Kirksville, Md

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.