

FILED MAY 16 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16694

State File No. ....

BIRTH NO. .... REG. DIST. NO. 233 PRIMARY REG. DIST. NO. 5813 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Wellsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Rural, Upper Centre</u>	
c. LENGTH OF STAY (In this place) <u>20 years</u>		d. STREET ADDRESS (If rural, give location) <u>1/3 mile north of Wellsville</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1/3 mile north of Wellsville</u>		d. STREET ADDRESS (If rural, give location) <u>1/3 mile north of Wellsville</u>	
3. NAME OF DECEASED (Type or Print) <u>WILLIAM PERRY ROBINSON</u>		4. DATE OF DEATH Month <u>May</u> (Day) <u>7</u> (Year) <u>1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>March-11-1896</u>
9. AGE (In years last birthday) <u>53</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 1 HRS. Hours _____ Min. _____	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Sitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Free Book Industry</u>	
11. BIRTHPLACE (State or foreign country) <u>Kingfisher, Okla.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>John P. Robinson</u>		13b. MOTHER'S MAIDEN NAME <u>Alma Hulvey</u>	
14. NAME OF HUSBAND OR WIFE <u>Jennie (Mrs) Robinson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u>488-09-0173</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Jennie Robinson</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Coronary Thrombosis</u>		19. ADDRESS <u>Wellsville, Mo.</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 hours</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) _____	
DUE TO (c) _____		DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4/201	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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>May 6, 1949</u> to <u>May 7, 1949</u> , that I last saw the deceased alive on <u>May 7, 1949</u> , and that death occurred at <u>2:54 p.m.</u> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>D. A. DeLand</u>		23b. ADDRESS <u>Wellsville Mo</u>	
23c. DATE SIGNED <u>5/9/49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>May-9-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Wellsville City</u>	
24d. LOCATION (City, town, or county) (State) <u>Wellsville Mo</u>		24e. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Roman Jr.</u>	
DATE REC'D BY LOCAL REG. <u>MAY 9, 1949</u>		REGISTRAR'S SIGNATURE <u>W. S. Roman Jr.</u>	
4251		FUNERAL DIRECTOR'S SIGNATURE <u>C. C. Rutledge</u>	
ADDRESS <u>Wellsville Mo</u>		ADDRESS <u>Wellsville Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

000

10.300  
10.48

JUN 27 1945

RECEIVED  
District Health Officer No. 9,  
District File Number MAY 14 1949  
Date Filed \_\_\_\_\_

JAN 14 1963

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 \_\_\_\_\_  
Student Embalmer

Signed CC Fisher

Licensed Embalmer No. 3059

P. O. Address Willsville 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.