

FILED AUG 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22862**

BIRTH NO. _____ REG. DIST. NO. **72** PRIMARY REG. DIST. NO. **4134** Registrar's No. **79**

1. PLACE OF DEATH a. COUNTY Chay		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Chay	
b. CITY OR TOWN Smithville		c. CITY OR TOWN Smithville	
c. LENGTH OF STAY (in this place) 50 yrs		d. STREET ADDRESS (If rural, give location) Platte County	
d. FULL NAME OF HOSPITAL OR INSTITUTION At Home			
3. NAME OF DECEASED (Type or Print) a. (First) LEONA b. (Middle) Wood c. (Last) Robbins		4. DATE OF DEATH (Month) (Day) (Year) July 22 1949	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH DEC. 30, 1876
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) SPENCER, INDIANA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME LYCURGUS WOOD		13b. MOTHER'S MAIDEN NAME MARTHA KELLY	
14. NAME OF HUSBAND OR WIFE FRANK P. ROBBINS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME FRANK P. ROBBINS		ADDRESS SMITHVILLE, MO	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ch. Nephritis DUE TO (c) Hypertension II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Paraplegia 3yrs	
19a. DATE 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) m.		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 March 10, 1949 , to July 27, 1949 , that I last saw the deceased alive on July 27, 1949 , and that death occurred at 10 p m. , from the causes and on the date stated above.			
23a. SIGNATURE W. S. Shelman (Degree or title)		23b. ADDRESS Smithville Mo	
23c. DATE SIGNED 7/23/49			
24a. BURIAL CREMATION REMOVAL (Specify) BURIAL		24b. DATE 7/24/49	
24c. NAME OF CEMETERY OR CREMATORY I.O.O.F. CEMETERY		24d. LOCATION (City, town, or county) (State) Smithville Missouri	
DATE REC'D BY LOCAL REG. July 24-1949		REGISTRAR'S SIGNATURE Beulah Kitchener	
25. FUNERAL DIRECTOR'S SIGNATURE McComas		ADDRESS FUNERAL HOME Smithville, Mo	

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

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RECEIVED AUG 1
District Health Officer No. 8,

District File Number _____

Date Filed 8-8-49

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 CP

CP Student Embalmer No. CP
working under my personal supervision.

CP
Student Student Embalmer

Signed Ewen Bagg
Licensed Embalmer No. 5940

P. O. Address Smithville, 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.