

FILED AUG 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23774

State File No.

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 244

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>INDEPENDENCE</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>INDEPENDENCE</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>510 N. DELAWARE AVE.</u>		d. STREET ADDRESS (If rural, give location) <u>510 N. DELAWARE AVE.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JENNIE</u> b. (Middle) <u>ROBINSON</u> c. (Last) <u>YINGLING</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>AUG.</u> <u>4</u> <u>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>NOV. 1, 1864</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (State or foreign country) <u>OWEN SOUND, CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>

13a. FATHER'S NAME <u>JOHN A. ROBINSON</u>	13b. MOTHER'S MAIDEN NAME <u>JANE N. WALKER</u>	14. NAME OF HUSBAND OR WIFE <u>ALBERT YINGLING</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>FRANK S. JENNINGS</u>	ADDRESS <u>510 N. DELAWARE INDEP. MO</u>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>49 dx</u> <u>4 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Tail - Fract left radius</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>aug 1-49</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Independence Jackson MO</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>aug 1-49 1 1/2 m</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fall</u>

22. I hereby certify that I attended the deceased from Aug 1, 1949, to Aug 4, 1949, that I last saw the deceased alive on Aug 4, 1949, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. B. Hickerson M.D.</u>	23b. ADDRESS <u>Independence MO</u>	23c. DATE SIGNED <u>aug 5</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>AUG 6, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MOUND GROVE CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>INDEPENDENCE, JACKSON, MO.</u>
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DATE REC'D BY LOCAL REG. <u>aug 6 1949</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>INDEPENDENCE, MO.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 9 RECD

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 _____

working under my personal supervision.

Signed
Student Embalmer

Student Embalmer No. _____

Signed _____

Licensed Embalmer No. 3156

P. O. Address Indpls 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.