

FILED NOV 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4732

37541

BIRTH NO.		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>4732</u>	
1. PLACE OF DEATH a. COUNTY <u>Wacitson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>1 week</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural - Wilson</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2209 Quincey</u>				d. STREET ADDRESS (If rural, give location) <u>R.F.D. # 1 0040</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u>		b. (Middle) <u>FRANCES</u>		c. (Last) <u>ROBINSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11 5 57</u>	
5. SEX <u>Female</u>		6. COLOR OF RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>6/12/1866</u>	
9. AGE (In years last birthday) <u>85</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>23</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Dallins</u>		13b. MOTHER'S MAIDEN NAME <u>Mildred Stuart</u>		14. NAME OF HUSBAND OR WIFE <u>Wm. H. 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 ADDRESS <u>Wm. H. Robinson Audrain Co. 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>Pulmonary Tuberculosis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Arterio Sclerotic Heart Dis with congestive heart failure</u>				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>Oct 5, 1957</u> , to <u>Nov. 5, 1957</u> , that I last saw the deceased alive on <u>Nov 5, 1957</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Paul A. G. Johnson MD</u> (Degree or title)				23b. ADDRESS <u>3011 A. Lundy Ave.</u>		23c. DATE SIGNED <u>11/6/57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Re moved</u>		24b. DATE <u>11/6/57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>—</u>		24d. LOCATION (City, town, or county) (State) <u>Mexico Missouri</u>	
DATE REC'D BY LOCAL REG. <u>11-6-57</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John P. Skil H. Co. Mo.</u>			

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

FEB 1964

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 *Richard C Carroll*

Licensed Embalmer No. *4829*

P. O. Address. *R. C. Me*

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.