

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28968

State File No. _____

FILED AUG 28 1953

BIRTH NO. _____		REG. DIST. NO. <u>146</u>		PRIMARY REG. DIST. NO. <u>3026</u>		Registrar's No. <u>334</u>		
1. PLACE OF DEATH a. COUNTY <u>Independence</u> <u>Independence, Mo</u> b. CITY (If outside corporate limits, write RURAL and give township) <u>Independence Mo 11 days</u> c. LENGTH OF STAY (In this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Independence Court</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> <u>Oak Grove Jackson, Mo</u> b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) <u>Oak Grove, Mo</u> d. STREET ADDRESS (If rural, give location) <u>1000</u>				
3. NAME OF DECEASED (Type or Print) <u>Helen Ann Robinson</u>			b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug - 21 - 1953</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 25 - 1905</u>		9. AGE (In years last birthday) <u>47</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editor - City National Bank</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Oak Grove Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>James Robinson</u>		13b. MOTHER'S MAIDEN NAME <u>Roberta A. Robinson</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	16. SOCIAL SECURITY NO. <u>496-039531</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Frank Robinson Oak Grove, Mo</u>				ADDRESS _____		
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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cholecystitis & Cholelithiasis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) <u>Cholecystitis & cholelithiasis</u>						<u>18 days</u>	
	DUE TO (c) <u>Infected gall bladder</u>						<u>7</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<u>Hepato-renal syndrome</u>						<u>3 days</u>	
19a. DATE OF OPERATION <u>Aug 14, 1953</u>	19b. MAJOR FINDINGS OF OPERATION. <u>Cholecystitis - c stones</u>						20. AUTOPSY? <u>584X</u> 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) _____		21d. (COUNTY) _____		21e. (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____	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>Aug 14</u> , 19 <u>53</u> , to <u>Aug 21</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Aug 21</u> , 19 <u>53</u> and that death occurred at <u>6:00 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>H. Hallen M.D.</u>				23b. ADDRESS <u>Independence, Mo</u>		23c. DATE SIGNED <u>Aug 21 - 53</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug - 23 - 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		24d. LOCATION (City, town, or county) <u>Oak Grove Mo</u>		(State) _____		
DATE REC'D BY LOCAL REG. <u>8-22-53</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Wells Funeral Home Oak Grove Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK

SEP 9 1953

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

R B Webb

Licensed Embalmer No. *2343*

P. O. Address

Blue spring N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.