S. No. 300
. 10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34561

State File No.

BIRTH NO. REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 177

1. PLACE OF DEATH
a. COUNTY Livingston
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chillicothe
c. LENGTH OF STAY (in this place) 5 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 402 Monroe

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri
b. COUNTY Livingston
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chillicothe 0593
d. STREET ADDRESS (If rural, give location) 402 Monroe

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle) Cookson
c. (Last) Robinson

4. DATE OF DEATH (Month) (Day) (Year) 10-23-54

5. SEX M
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 10-31-1878
9. AGE (In years last birthday) 75 — If under 1 year: Months Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (City and State or Foreign Country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Richard Robinson
13b. MOTHER'S MAIDEN NAME Elizabeth Dale
14. NAME OF HUSBAND OR WIFE A nna B. Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS Mrs. Anna B. Robinson, Chillicothe, 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Chr. Cerebral Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 334 X
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1953, *to* Oct 23, 1954, *that I last saw the deceased alive on* Oct 23, 1954, *and that death occurred at* 9:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) D M Dowell, M.D.
23b. ADDRESS Chillicothe Mo
23c. DATE SIGNED 10/25/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-26-54
24c. NAME OF CEMETERY OR CREMATORY Monroe
24d. LOCATION (City, town, or county) (State) Ludlow, Missouri

DATE REC'D BY LOCAL REG. 10/25/54
REGISTRAR'S SIGNATURE Francis B. Neill
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS Norman Funeral Home, Chillicothe, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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 Joseph M. Gibson

Licensed Embalmer No. 4769

P. O. Address Chillicothe, Missouri.

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.