

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39431  
STATE FILE NUMBER

FILED DEC 12 1957

Registration District No. 43 Primary Registration District No. 5136 Registrar's No. 34

S. 300  
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Butler</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Butler</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Harviell Beaver Dam Twp</b>		Inside Limits <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	c. CITY OR TOWN <b>Harviell</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rt. 1, Harviell, Mo.</b>		Length of stay in 1b <b>17 years</b>	d. STREET ADDRESS (If outside, give location) <b>(Croppersville Community)</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Sharley Robinson</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>14</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1888</b>		9. AGE (In years last birthday) <b>69</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Marston, Mo.</b>	
13a. FATHER'S NAME <b>Weber Randolph Robinson</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Annie Robinson</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Annie Robinson, Harviell, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b>					?
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>1 Nov 57</b> to <b>14 Nov 57</b> and last saw him alive on <b>10 Nov 57</b> Death occurred on <b>1045 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>[Signature]</b> (Degree or title)			22b. ADDRESS <b>321 Oak, Poplar Bluff, Mo</b>		22c. DATE SIGNED <b>21 Nov 57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/17/1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Croppersville</b>		23d. LOCATION (City, town, or county) (State) <b>at. One, Harviell Mo.</b>
24. FUNERAL DIRECTOR <b>Peoples Funeral Home</b> ADDRESS <b>Poplar Bluff, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>12/2/57</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b> By <b>mm</b>

RECEIVED

DEC 9 1957

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Wallace R Knight

Licensed Embalmer No. 2514

P. O. Address 822 FARM  
Porter, Pa

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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