

pt. Health,
, & Welfare
S. Public
th Service

FILED DEC 23 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46935
STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 6093 Registrar's No. 241

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall Township		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Excelsior Springs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. State School Marshall		Length of stay in lb 16 yrs.	d. STREET ADDRESS (If outside, give location) Route 2

3. NAME OF DECEASED (Type or print) First Robert Middle Martin Last Bishop			4. DATE OF DEATH Month Dec. Day 20, Year 1957	
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1930	9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Excelsior Springs, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William Grant Bishop	13b. MOTHER'S MAIDEN NAME Gertrude May Smith	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mo. State School records, Marshall, Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Congenital Cerebral Anomaly	
	DUE TO (c) Epileptic Seizure	330X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Epileptic Seizure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT 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 Marshall, Mo.	COUNTY Clay	STATE Missouri
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21. I attended the deceased from Sept., 1955 to Dec., 1957 and last saw him ^{her} alive on Dec. 3, 1957 Death occurred at 4:05 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.	
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22. SIGNATURE (Degree or title) E. Lee McCorkle M. D.	22b. ADDRESS Marshall, Mo.	22c. DATE SIGNED 12-20-57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-21-1957	23c. NAME OF CEMETERY OR CREMATORY Salem Cemetery	23d. LOCATION (City, town, or county) (State) Excelsior Springs Mo
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24. FUNERAL DIRECTOR Harry Hershberger	ADDRESS Marshall Mo	25. DATE RECD. BY LOCAL REG. 12-21-57	26. REGISTRAR'S SIGNATURE Carl H. Best
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(Licensed Embalmer's Statement on Reverse Side)

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
MEDICAL CERTIFICATION

52g

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FEB 21 1964

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
X by me, or by, Student Embalmer No.
working under my personal supervision.

Student

Signature of Student Embalmer

Signed: *Joseph R. Markler*

Licensed Embalmer No. *4571*

P. O. Address *Marshall, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.