

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011149
STATE FILE NUMBER

FILED APR 8 1958

Registration District No. 297 Primary Registration District No. 3057 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY <u>Ray</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Lexington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clements Rest Home</u>			Length of stay in lb <u>5 mo</u>			d. STREET ADDRESS (If outside, give location) <u>1708 Bloom</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>30</u> Year <u>1958</u>					
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>BELLE</u> Last <u>ROBERTSON</u>							
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July, 1, 1884</u>		9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 26 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTHPLACE (City and state or country) <u>Lafayette County Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Geo. W Robertson</u>			
14. MOTHER'S MAIDEN NAME <u>Miss. Lucy Payne, Lexington, Mo.</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Miss. Lucy Payne, Lexington, Mo.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>4201H</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Squamous Cell Carcinoma of Left Fallopian Tube</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2nd</u>							
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 <u>5:15 p</u> Month <u>5</u> Day <u>15</u> Year <u>58</u>			
20d. INJURY OCCURRED WHILE AT WORK <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		COUNTY STATE	
21. I attended the deceased from <u>1-15-58</u> to <u>3-30-58</u> and last saw her alive on <u>3-30-58</u> Death occurred at <u>5:15 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Thomas B. Cook, M.D.</u>				22b. ADDRESS <u>Richmond Mo.</u>		22c. DATE SIGNED <u>Mar. 31, 1958</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April, 1, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		23d. LOCATION (City, town, or county) (State) <u>South of Higginville, Mo.</u>	
24. FUNERAL DIRECTOR <u>Joseph T. Tenney, Lexington, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>4-2-1958</u>		26. REGISTRAR'S SIGNATURE <u>Mabel Jackson</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service, 300-56, Doctor, coroner, etc. must use only standard memoranda in form to be filled out by physician or other person who has attended the deceased. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related. Coroner must be casually related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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STATEMENT BY LICENSED EMBALMER

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

Student.....
Signature of Student Embalmer

Signed.....
Leo McLean

Licensed Embalmer No. 29

P. O. Address.....
Lehigh

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.