. Health,
& Welfare
. Public
h Service
96
0
S. 300
. 1-57

Dr. WAKEMAN

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-025208
STATE FILE NUMBER

FILED JUL 21 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 711

1. PLACE OF DEATH
a. COUNTY GREENE
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) SPRINGFIELD — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) BURGE HOSP. — Length of stay in lb 28 YRS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY GREENE
c. CITY OR TOWN SPRINGFIELD 0396 0 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 1513 NICHOLS — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First FRANK Middle Last ROBINSON
4. DATE OF DEATH Month Day Year JULY 11 1958

5. SEX MALE 0
6. COLOR OR RACE WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH AUG. 30 1884
9. AGE (In years last birthday) 73 — 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) RETIRED MECHANIC
10b. KIND OF BUSINESS OR INDUSTRY AUTO
11. BIRTHPLACE (City and state or country) RENNSELAER, INDIANA
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME ADDISON ROBINSON
13b. MOTHER'S MAIDEN NAME LETTIE BURROUGHS
14. NAME OF HUSBAND OR WIFE GEORGIA ROBINSON (DEC,)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 491-05-2521
17. INFORMANT Address MRS. BEATRICE CHILES SPRINGFIELD MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Emphysema Acute — INTERVAL BETWEEN ONSET AND DEATH Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Bronchitis — 5 years
DUE TO (c) 5020
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Uraemia - Pyelonephritis
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 June 1958, to 7-11-58 and last saw ~~her~~ him alive on 7-11-58
Death occurred at 10 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J Newton Wakeman MD
22b. ADDRESS Springfield, Mo
22c. DATE SIGNED 7-12-58

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 7/14/58
23c. NAME OF CEMETERY OR CREMATORY HAZELWOOD
23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.

24. FUNERAL DIRECTOR H.H. LOHMEYER ADDRESS SPRINGFIELD, MO.
25. DATE RECD. BY LOCAL REG. 7/14/58
26. REGISTRAR'S SIGNATURE Effie G Melton

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 R L McCann

Licensed Embalmer No. 27 77

P. O. Address Springfield 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.