

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008616

STATE FILE NUMBER

FILED APR 7 1959

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 96

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-57

|                                                                                                          |  |                                                                                                                                          |                                                                                                                             |
|----------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Callaway</u>                                                           |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Lewis</u> |                                                                                                                             |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Fulton</u>                       |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                     | c. CITY OR TOWN <u>LaGrange,</u> <u>0560</u>                                                                                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>St. Hospital No. 1</u> |  | Length of stay in 1b<br><u>3wk. 4da.</u>                                                                                                 | d. STREET ADDRESS (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

|                                                                                                        |                                  |                                                                                                                                                             |                                                                       |  |                                               |
|--------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--|-----------------------------------------------|
| 3. NAME OF DECEASED (Type or print)<br>First <u>William</u> Middle <u>Albert</u> Last <u>Robinson</u>  |                                  |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <u>March</u> Day <u>31</u> Year <u>1959</u> |  |                                               |
| 5. SEX<br><u>Male</u>                                                                                  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9/26/1879</u>                                  |  | 9. AGE (In years) <u>78</u><br>(At birthday)  |
| 10a. USUAL OCCUPATION (Give kind of work done during preceding life, even if retired)<br><u>Farmer</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY                                                                                                                           | 11. BIRTHPLACE (City and state or country)<br><u>Missouri</u>         |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |

|                                                 |                                                      |                                             |
|-------------------------------------------------|------------------------------------------------------|---------------------------------------------|
| 13a. FATHER'S NAME<br><u>Littleton Robinson</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Martha Blackwell</u> | 14. NAME OF HUSBAND OR WIFE<br><u>-----</u> |
|-------------------------------------------------|------------------------------------------------------|---------------------------------------------|

|                                                                                                                             |                                           |                                                           |         |
|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------|---------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>Unknown</u> | 16. SOCIAL SECURITY NO.<br><u>Unknown</u> | 17. INFORMANT<br><u>State Hospital No. 1, Fulton, Mo.</u> | Address |
|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------|---------|

|                                                                                                                                                                                                                                                                                                         |  |                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>                                                                                                                                     |  | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Bleeding gastric ulcer</u> |  |                                  |
| 19. WAS AUTOPSY PERFORMED?<br>1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                     |  | <u>4261</u>                      |

|                                                                                                           |                                                                                              |  |
|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--|
| 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<br>Hour _____<br>Month, Day, Year _____<br>a.m. _____<br>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<br>COUNTY STATE |
|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------------------|

21. St. Hospital attended the deceased from March-6-59 to March-31-59 and last saw her/him alive on March 31-59  
Death occurred at 6:35 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

|                                                |                                             |                                    |
|------------------------------------------------|---------------------------------------------|------------------------------------|
| 22a. SIGNATURE<br><u>Erwin Leonhardt, M.D.</u> | 22b. ADDRESS<br><u>State Hospital No. 1</u> | 22c. DATE SIGNED<br><u>3-31-59</u> |
|------------------------------------------------|---------------------------------------------|------------------------------------|

|                                                     |                                   |                                                              |                                                                      |
|-----------------------------------------------------|-----------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------|
| 23a. BURIAL OR CREMATION (Specify)<br><u>Burial</u> | 23b. DATE<br><u>April 2, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Midway Cemetery</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Lewis Co. Mo</u> |
|-----------------------------------------------------|-----------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------|

|                                                                  |                                                      |                                                     |
|------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------|
| 24. FUNERAL DIRECTOR<br><u>W. Kenneth Bailey</u><br>LaGrange, Mo | 25. DATE RECD. BY LOCAL REG.<br><u>March 31-1959</u> | 26. REGISTRAR'S SIGNATURE<br><u>Martha Lawrence</u> |
|------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------|

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 .....

Licensed Embalmer No.....

P. O. Address.....

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.