

Health,
Welfare,
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016860

STATE FILE NUMBER

FILED MAY 18 1959

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 491

300
-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital Most of life	Length of stay in 1b 0117	STREET ADDRESS (If outside, give location) 3517 St. Joseph Ave	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WILLIAM Middle HOWDEN Last ROBBINS			4. DATE OF DEATH Month May Day 8 Year 1959		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1895	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegrapher	10b. KIND OF BUSINESS OR INDUSTRY Western Union	11. BIRTHPLACE (City and state or country) Skidmore, Mo.,	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Oren Robbins	13b. MOTHER'S MAIDEN NAME Susan Elizabeth Thompson	14. NAME OF HUSBAND OR WIFE Mrs. Leona Robbins
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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. 491-09-1650	17. INFORMANT Mrs. Leona Robbins, St. Joseph, Mo.,	Address 3517 St. Joseph Ave
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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) Acute Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH April 30, 1959 Yrs.
DUE TO (b) Arteriosclerosis Gen.		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchial Asthma - Gall Bladder Disease 4201		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 Month, Day, Year a.m. p.m.		

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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
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21. I attended the deceased from **6-20-56** to **5-8-59** and last saw ^{him} alive on **5-8-59**
Death occurred at **10:55 P.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert A. Kieber, M.D.	22b. ADDRESS St. Joseph, Mo.	22c. DATE SIGNED 5-9-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May, 11th, 1959	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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24. FUNERAL DIRECTOR Stoney Funeral Home (918)	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. May 11, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Standell
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
Dr. Robert W. Kieber
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

No. _____ Date _____
 Name of Deceased _____
 Address _____
 City _____ State _____
 County _____
 Date of Death _____
 Cause of Death _____
 Place of Death _____
 Name of Physician _____
 Name of Undertaker _____
 Name of Embalmer _____
 Name of Student Embalmer _____
 Name of Witness _____
 Name of Witness _____
 Name of Witness _____

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 Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St. Joseph, 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.