

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-027862

## FILED VS AUG 1 0 1959

STATE FILE NUMBER

 Registration District No. 91 Primary Registration District No. 4514 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Sullivan</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Green City</u>		Length of stay in 1b <u>9 months</u>		c. CITY OR TOWN <u>Green City</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>Own home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>No street address</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>-----</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2/22/1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>      </u> Days <u>      </u>	IF UNDER 24 HR Hours <u>      </u> Min. <u>      </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>General farming</u>		11. BIRTHPLACE (City and state or country) <u>Akersville, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Charles H. Robinson</u>			13b. MOTHER'S MAIDEN NAME <u>Martha L. Boyd</u>			14. NAME OF HUSBAND OR WIFE <u>Ida May Robinson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>498-40-7067</u>		17. INFORMANT Address <u>Mrs. Clarence Walker, Green City, 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>Cardiac, renal syndrone</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>senile</u>							Unknown	
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ a.m. _____ p.m.		Month, Day, Year _____						
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 _____, to _____, and last saw her/him alive on _____. Death occurred at _____ <u>8 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>E. W. Simpson, D.O.</u> (Degree or title)				22b. ADDRESS <u>Milan, Missouri</u>			22c. DATE SIGNED <u>7/31/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/31/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green City Cemetery</u>		23d. LOCATION (City, town, or county) <u>Green City, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Glenn E. Kent</u> ADDRESS <u>Green City, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>8-6-59</u>			26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City

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