

## I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 8 1960

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Registration District No. \_\_\_\_\_ Primary Registration District No. 3006 Registrar's No. 64

STATE FILE NUMBER

60-000172

1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>NEW MADRID</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Length of stay in 1b <b>56 Days</b>		c. CITY OR TOWN <b>MATTHEWS</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>University of Mo Medical Center</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>ROUTE # I</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LILLIAN</b> Middle <b>Robinson</b> Last <b>BEVERLY</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>2</b> Year <b>60</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10-30-94</b>	9. AGE (last birthday) <b>66</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (City and state or country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>VANTS ROBINSON</b>			13b. MOTHER'S MAIDEN NAME <b>CHARITY FAIR</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>UNIVERSITY of Mo Medical Records Hospital CHAT</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma of bladder</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b>6 mo.</b>	
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 checked="" 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 <b>12-8-59</b> to <b>2-2-60</b> and last saw her <b>alive</b> on <b>2-2-60</b> Death occurred at <b>1:25</b> <b>p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>J. R. Ellis, MD.</b> (Degree or title)				22b. ADDRESS <b>U. of Missouri Medical Center</b>		22c. DATE SIGNED <b>2 Feb 60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/4/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>		23d. LOCATION (City, town, or county) <b>Matthews, Missouri</b>		(State)		
24. FUNERAL DIRECTOR <b>Lyman Sprinkle Columbia, Missouri</b>			25. DATE RECD. BY LOCAL REG. <b>Feb 3 1960</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 - AT 827

**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 *Gary A. [Signature]*

Licensed Embalmer No. 442

P. O. Address Columbus

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.