

RJ DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002265

FILED VS FEB 15 1960

Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 20 STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Johnson</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Warrensburg</u>		a. STATE <u>Missouri</u> COUNTY <u>Johnson</u>		c. CITY OR TOWN <u>Warrensburg</u>	
Length of stay in 1b <u>Life</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>200 W. Gay St.</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Warrensburg Medical Center Inc.</u>				d. STREET ADDRESS (If outside, give location) <u>200 W. Gay St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Wilbur</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>8,</u> Year <u>1960</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>11-13-91</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR		IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor, Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Drug Store</u>		11. BIRTHPLACE (City and state or country) <u>Warrensburg, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>	
13a. FATHER'S NAME <u>Franklin West Robinson</u>		13b. MOTHER'S MAIDEN NAME <u>Louise McCoy</u>		14. NAME OF HUSBAND OR WIFE <u>Margaret Robinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.I.</u>		16. SOCIAL SECURITY NO. <u>W.W.I.</u>		17. INFORMANT Address <u>Warrensburg</u> <u>Margaret Robinson, 200 West Gay St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
IMMEDIATE CAUSE (a) <u>Chr. Lymphatic Leukemia</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) _____	
						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"/> N- <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 checked="" 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 <u>Feb 1959</u> to <u>2-8-60</u> and last saw ^{her} him _{live} on <u>2-8-60</u> Death occurred at <u>9:25 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Rhee Cooper</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>Warrensburg, Missouri</u>		22c. DATE SIGNED <u>2-9-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-10-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Warrensburg, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Sweeney Phillips, Warrensburg, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>2-10-60</u>		26. REGISTRAR'S SIGNATURE <u>Earl West / Deputy</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

FEB 19 66

MAR 22 1960

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 Morris D Bailey

Licensed Embalmer No. 4887

P. O. Address Waverly

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.