

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007179

FILED VS. MAR 15 1960

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 44

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Sullivan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe	Length of stay in 1b 45 days	c. CITY OR TOWN Green City	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1104 Cooper St.	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) No street address	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Raymond Pearl Robinson			4. DATE OF DEATH Month Day Year Feb. 29, 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/14/1896	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming	11. BIRTHPLACE (City and state or country) Pollock, Mo.	12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME John Robinson		13b. MOTHER'S MAIDEN NAME Dell Ledford		14. NAME OF HUSBAND OR WIFE Ethel Robinson		
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. Don't know	17. INFORMANT Address Donnie L. Robinson, Green City, Mo.			

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 1 hr unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Coronary artery disease	
	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 **Jan. 1960** to **Feb 29, 1960** and last saw him alive on **Feb. 27, 1960**
Death occurred at **3:50 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William L. Fair, M.D.	22b. ADDRESS Chillicothe, Mo.	22c. DATE SIGNED 3/1/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/2/1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) Green City, Mo.
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24. FUNERAL DIRECTOR ADDRESS Allen E. Kent & Son, Green City, Mo.	25. DATE RECD. BY LOCAL REG. 3/9/60	26. REGISTRAR'S SIGNATURE Frances B Neill
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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.