

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-007729

AMENDED Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 243 STATE FILE NUMBER

FILED VS MAR 14 1961

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|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> | | Length of stay in lb <u>5 mons.</u> | c. CITY OR TOWN <u>Kansas 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>St. Joseph State Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>2551 Holmes St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle Last <u>Robinson</u> | | | 4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1961</u> |
| 5. SEX <u>Female</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>Jan. 31, 1889</u> |
| 9. AGE (last birthday) <u>72</u> | | 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) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u> | 11. BIRTHPLACE (City and state or country) <u>Brookfield, Missouri.</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>Benjamin F. Schenck</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Lillian Howe</u> | | 14. NAME OF HUSBAND OR WIFE <u>Earl T. 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>Unknown</u> | 17. INFORMANT Address <u>Earl T. Robinson Kansas 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>Pulmonary Embolism</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary occlusion</u> | | | <u>Unknown</u> |
| DUE TO (c) <u>Generalized Arteriosclerosis</u> | | | <u>Unknown</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>A patient in St. Joseph State Hosp. since Oct. 7, 1960.</u> | | | 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 checked="" type="checkbox"/> NO <input 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.) <u>Diagnosed Chr. brain syndrome with senile brain Disease.</u> | |
| 20c. TIME OF INJURY Hour 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 <u>Mar. 7, 1961.</u> to <u>Mar. 7, 1961.</u> and last saw her/him alive on <u>Mar. 7, 1961.</u> Death occurred at <u>10:45 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (D, M, or title) <u>H. F. Mundy M.D.</u> | | 22b. ADDRESS <u>St. Joseph Mo Mar 8-1961</u> | 22c. DATE SIGNED |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>Mar. 8, 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Freeman Mortuary</u> | 23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Meierhoffer-Fleeman, Inc., St. Joseph, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Mar. 8, 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u> |

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

H.F. Mundy M.D. MEDICAL CERTIFICATION

MAR 15 1967

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 Albert E. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph

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.