

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=61-025448

3604

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1

FILED AUG 8 1961

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 1 yr. 7 months		c. CITY OR TOWN Kansas 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 Trinity Lutheran Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3005 Main		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Last Robbins				4. DATE OF DEATH Month July Day 19 Year 1961									
5. SEX Female		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 July 30, 1910		9. AGE (last birthday) 50		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) Ward Clerk				10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (City and state or country) Kansas		12. CITIZEN OF WHAT COUNTRY U. S. A.					
13a. FATHER'S NAME D. O. Harrison				13b. MOTHER'S MAIDEN NAME Olive Holman				14. NAME OF HUSBAND OR WIFE Lloyd Robbins					
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.				17. INFORMANT Address Mary Elwood, Rt., 3, Paola, Kansas					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage								INTERVAL BETWEEN ONSET AND DEATH 12 hours					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Hypertension, Cerebral		DUE TO (c) Hypertension, Generalized				1 yr.		1 yr.			
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 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 Month, Day, Year a.m. p.m.													
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>1-9-61</u> to <u>7-19-61</u> and last saw her <u>him</u> alive on <u>7-19-61</u> Death occurred at <u>9:50 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Otto W. Theel M.D.				22b. ADDRESS 4301 Main St. KC Mo				22c. DATE SIGNED 7-19-61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE July 19, 1961		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) Wellsville, Kansas		(State)					
24. FUNERAL DIRECTOR ADDRESS Stine & McClure, Kansas City, Mo.				25. DATE RECD. BY LOCAL REG. 7-19-61		26. REGISTRAR'S SIGNATURE Ruth Long							

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Otto W. Theel

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 William M. Turner

Licensed Embalmer No. 4648

P. O. Address Kansas City, Mo.

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.