

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=62-005771**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 61

**FILED FEB 26 1962**

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in lb <u>7Yr-5Mo</u>	c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Kermit</u> Middle <u>A</u> Last <u>Robinson</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1962</u>	
---	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-6-1908</u>	9. AGE (last birthday) <u>53</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>porter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	--	---	--

13a. FATHER'S NAME <u>S. C. Robinson</u>	13b. MOTHER'S MAIDEN NAME <u>Clara Reynolds</u>	14. NAME OF HUSBAND OR WIFE <u>none</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>none</u>	17. INFORMANT Address <u>State Hospital No. 1, Fulton, 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>Hyperglycemia with ketosis</u>		INTERVAL BETWEEN ONSET AND DEATH
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"/> 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.)
---	---	--

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.) <u>State Hospital No. 1</u>	20f. CITY, TOWN, OR LOCATION <u>Hannibal</u>	COUNTY <u>Marion</u>	STATE <u>Missouri</u>
---	--	---	---	-------------------------	--------------------------

21. Attended the deceased from <u>2/21/62 at 9:15 p.m.</u> to <u>2/21/62</u> and Death occurred at <u>2/21/62 at 9:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE (Degree or title) <u>James K. Otterhusel M.D.</u>	22b. ADDRESS <u>Fulton, Mo.</u>	22c. DATE SIGNED <u>2/22/62</u>
---	------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb 24-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Robinson Cemetery</u>	23d. LOCATION (City, town, or county) <u>Hannibal</u>	State <u>Mo</u>
--	---------------------------------	--	--	--------------------

24. FUNERAL DIRECTOR <u>Edmund E Robinson</u>	ADDRESS <u>Hannibal Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Feb 22-1962</u>	26. REGISTRAR'S SIGNATURE <u>Marette Lawrence</u>
--	-------------------------------	--	--

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

FEB 28 1962

**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 Edward E. Robinson

Licensed Embalmer No. 4999

P. O. Address Hannibal, 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.