

Health, Welfare
Public
Service

300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Div. Sec. R. C. Miller

HEALTH DEPARTMENT OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22803

STATE FILE NUMBER

FILED JUL 23 1956

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 223

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| 1. PLACE OF DEATH a. COUNTY Boone | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Clay | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Xenia 4120g Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Shady Lawn Rest Home Length of stay in lb 3yrs. | | d. STREET ADDRESS (If outside, give location) ----- Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Sarah Middle Ann Last Robinson | | | 4. DATE OF DEATH Month 7 Day 12 Year 1956 | | | |
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|----------------------|-------------------------------|---|---------------------------------------|---|--|--|
| 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 16, 1865 | 9. AGE (In years last birthday) 90 | IF UNDER 1 YEAR Months 0 Days 0 | IF UNDER 24 HRS. Hours 0 Min. 0 |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10b. KIND OF BUSINESS OR INDUSTRY home | 11. BIRTHPLACE (City and state or country) Xenia, Illinois | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13. FATHER'S NAME John D. Pentecost | 14. MOTHER'S MAIDEN NAME Sarah Davis |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ----- | 16. SOCIAL SECURITY NO. ----- | 17. INFORMANT Mrs. Minta M. Bates Address Columbia, Mo. |
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| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH 7 |
| 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 (n) 4200 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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.) 4200 |
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| 20c. TIME OF INJURY. Hour ----- Month ----- Day ----- Year ----- a. m. ----- p. m. ----- | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) ----- | 20e. CITY, TOWN, OR LOCATION ----- COUNTY ----- STATE ----- |
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| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> | 20f. CITY, TOWN, OR LOCATION ----- COUNTY ----- STATE ----- |
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| 21. I attended the deceased from Jan 54 to July 12, 56 and last saw her alive on June 28, 56 Death occurred at 11:30 p. m. on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Name or title) LeRoy J. Miller M.D. | 22b. ADDRESS 224 N. 8th Columbia | 22c. DATE SIGNED 13 Jul 56 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE 7-14-56 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | 23d. LOCATION (City, town, or county) (State) Columbia, Mo. |
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| 24. FUNERAL DIRECTOR Lynn Sprinkle ADDRESS Columbia, Mo. | 25. DATE RECD. BY LOCAL REG. July 14 1956 | 26. REGISTRAR'S SIGNATURE Mrs. R E Palmer |
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(Licensed Embalmer's Statement on Reverse Side)

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 *Lynman H. Spurdle*

Licensed Embalmer No. *401*

P. O. Address *Columbia*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.