

FILED SEP 9 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28469

STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 169

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Prairie Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN Lee's Summit Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION JACKSON Co. Hosp. Length of stay in lb 5 mo.		d. STREET ADDRESS (If outside, give location) 510 S. GREEN Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruth Middle A. Last WINN		4. DATE OF DEATH Month Aug. Day 21 Year 1957	
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 June 7 - 1878
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 79 IF UNDER 1 YEAR: Months 7 Days 9 IF UNDER 24 HRS.: Hours 0 Min. 0
11. BIRTHPLACE (City and state or country) Paris, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Robinson		14. MOTHER'S MAIDEN NAME Crinda McCann	
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. None	17. INFORMANT Mrs Margaret Haynes Tampa Fla. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH 4343
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Cardiac Decompensation with Hypostasis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) 9 generally good ANTERIOR below			
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.) D
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 Lee's Summit
		20g. COUNTY Lee's Summit Mo.	20h. STATE Mo.
21. I attended the deceased from 3-13-57 to 8-21-57 and last saw her alive on 8-20-57 Death occurred at 1:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Rand W. Robinson M.D.		22b. ADDRESS Jackson City Mo.	22c. DATE SIGNED 8-21-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/24/1957	23c. NAME OF CEMETERY OR CREMATORY Lee's Summit	23d. LOCATION (City, town, or county) (State) Lee's Summit Mo.
24. FUNERAL DIRECTOR Langsford Funeral Home ADDRESS Lee's Summit Mo.		25. DATE RECD. BY LOCAL REG. Aug 22-57	26. REGISTRAR'S SIGNATURE R. B. Langsford

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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(Licensed Embalmer's Statement on Reverse Side)

SEP 3 1957

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 *H. B. Langford*

Licensed Embalmer No.

P. O. Address *Lee's Su*

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