

FILED OCT 7 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30692**

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>343</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Knox</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Kirksville Mo.</u>)		c. LENGTH OF STAY (in this place) <u>32 days</u>		c. CITY OR TOWN <u>Knox City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Laughlin Hospital</u>				STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>KATIE</u>		b. (Middle) <u>LEE</u>		c. (Last) <u>ROBINSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 22 1957</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Aug 13, 1876</u>	
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>1</u>		IF UNDER 24 HRS. Days <u>12</u>		IF UNDER 1 HRS. Hours <u></u> Min. <u></u>	
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 _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Knox Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Warden Thompson</u>			13b. MOTHER'S MAIDEN NAME <u>Armindia A Downing</u>			14. NAME OF HUSBAND OR WIFE <u>John T Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Zoa Strickler Knox City Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Auricular Fibrillation</u>				<u>?</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) <u>4201</u> (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Aug 28, 1957</u> , to <u>Sept 22, 1957</u> , that I last saw the deceased alive on <u>Sept 22, 1957</u> , and that death occurred at <u>1:40 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>A.T. Rhoads D.O.</u> (Degree or title)				23b. ADDRESS <u>Kirksville, Mo</u>		23c. DATE SIGNED <u>9-23-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 25 57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>La Belle Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Lewis Co. Missouri</u>	
DATE REC'D BY LOCAL REG. <u>9-30-1957</u>		REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>A. J. Seeger Knox City Mo</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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OCT 18 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by A. B. Primer, Student Embalmer No. 544

working under my personal supervision.

Student A. B. Primer Signed Mrs J. W. Hudson

Signature of Student Embalmer

Licensed Embalmer No. 29

P. O. Address Edina

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