

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36494

STATE FILE NUMBER

FILED OCT 22 1957

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 167

V. S. 300
ev. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Laclede.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Lebanon, Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Richland, Missouri</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>Knox Nursing Home</u>		Length of stay in lb <u>9 mos.</u>	d. STREET ADDRESS <u>None.</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES Q UINCY ROBINSON.</u>			4. DATE OF DEATH Month Day Year <u>Oct. 9, 1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1872</u>
9. AGE (In years last birthday) <u>85</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Constable.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer.</u>	11. BIRTHPLACE (City and state or country) <u>Richland, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Joshia Whitfield Robinson</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Harris.</u>		14. NAME OF HUSBAND OR WIFE <u>Ethel V. Fugatt.</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 <u>Stanley Robinson</u> Address <u>Richland, 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>Coronary Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 Min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardiac Decompensation</u>			<u>1 Hr.</u>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in Part I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>4201</u>	
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>Sept. 30, 1957</u> to <u>Oct. 9, 1957</u> and last saw her alive on <u>Oct. 9, 1957</u> Death occurred at <u>9:25</u> P on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Oz Bolner</u> (Degree or title) <u>D.O.</u>		22b. ADDRESS <u>Lebanon, Missouri</u>	22c. DATE SIGNED <u>10-11-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct/12/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Richland, Mo</u>
24. FUNERAL DIRECTOR <u>Hedges Funeral Home</u> ADDRESS <u>Richland, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-11-1957</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. Day</u>

Received 10-21-57
Laclede County Health Unit
File No. 167
Date Filed 10-21-57

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 Clarence E. Mass.....

Licensed Embalmer No. 4896
P. O. Address Waynesville

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.