

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002045
State File No.

FILED FEB 9 1959

BIRTH NO. _____ REG. DIST. NO. 167 PRIMARY REG. DIST. NO. 3040 Registrar's No. 36

1. PLACE OF DEATH
a. COUNTY Livingston
b. CITY OR TOWN Chillicothe
c. LENGTH OF STAY (in this place) 1 yr
d. FULL NAME OF HOSPITAL OR INSTITUTION Susan Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Livingston
c. CITY OR TOWN Ludlow 0 590
d. Is Residence within limits of a city or incorporated town? Yes No
STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED
a. (First) Nettie b. (Middle) _____ c. (Last) Robinson

4. DATE OF DEATH Jan. 30, 1959
(Month) (Day) (Year)

5. SEX Female
6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 24 April 1869

9. AGE (In years, less birthday) 89
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) At Home

10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (City and State or Foreign Country) Dawn, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME William Anderson

13b. MOTHER'S MAIDEN NAME Caroline

14. NAME OF HUSBAND OR WIFE William T. Robinson

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'S SIGNATURE OR NAME ADDRESS Mrs. Ferroll Rea: Dawn, Missouri

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, asphyxia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Vascular
DUE TO (c) Disease
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH 4 days

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? 2
YES NO

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) (COUNTY) (STATE) 331x

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from my, 1958, to 31 Jan, 1957, that I last saw the deceased alive on 30 Jan, 1959, and that death occurred at 9-2 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) V D Vandiver M.D.

23b. ADDRESS Chillicothe Mo

23c. DATE SIGNED 31 Jan 59

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 2-1-59

24c. NAME OF CEMETERY OR CREMATORY Monroe

24d. LOCATION (City, town, or county) (State) Ludlow, Missouri

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 1-31-59 Frances B. Neill

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Norman Funeral Home, Chillicothe, Mo.

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

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 *Elton Norman*.....

Licensed Embalmer No. *403*.....

P. O. Address *Chillicothe*.....

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.