THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-018567
STATE FILE NUMBER

FILED MAY 18 1959

Registration District No. 251 Primary Registration District No. _____ Registrar's No. 120

1. PLACE OF DEATH
a. COUNTY Nodaway
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Barnard — Inside Limits Yes ☐ No ☑
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Home — Length of stay in lb 69 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Nodaway
c. CITY OR TOWN Barnard — Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) 0740 — Reside on Farm Yes ☑ No ☐

3. NAME OF DECEASED (Type or print) First Alvin Middle L. Last Robison

4. DATE OF DEATH Month 5 Day 10 Year 59

5. SEX male
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9-20-1889
9. AGE (In years last birthday) 69 — 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) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (City and state or country) Barnard, Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Daniel Robison
13b. MOTHER'S MAIDEN NAME Sarah Goforth
14. NAME OF HUSBAND OR WIFE none

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Donna Woods Address Maryville Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH Instant
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 (a) 4201
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 ——, to —— and last saw her/him alive on ——
Death occurred at 6:15 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) B. F. Bland M.D.
22b. ADDRESS Maryville Mo
22c. DATE SIGNED 5/10/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 5-12-59
23c. NAME OF CEMETERY OR CREMATORY Masonic Cem.
23d. LOCATION (City, town, or county) Barnard (State) Mo

24. FUNERAL DIRECTOR G. W. Atchison ADDRESS Maryville Mo
25. DATE RECD. BY LOCAL REG. 5-11 59
26. REGISTRAR'S SIGNATURE Bess Wolf

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

JUN 3 1959

JUN 3 1959

MAY 26 1959

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 G. M. Atkins

Licensed Embalmer No. 327

P. O. Address Barnesville

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.