

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-035887**

Dr. Maples

FILED VS OCT 26 1959

STATE FILE NUMBER

INDEXED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1133

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Length of stay in 1b <b>60 YRS.</b>		c. CITY OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BAPTIST HOSP.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1851 S. FRANKLIN</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LEONARD F. ROBBERSON</b>				4. DATE OF DEATH Month Day Year <b>OCT. 22 1959</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10/12/99</b>	9. AGE (last birthday) <b>60</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MANAGER - JOPLIN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DISTRI. CO.</b>		11. BIRTHPLACE (City and state or country) <b>GREENE CO. MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>EDWIN ROBBERSON</b>			13b. MOTHER'S MAIDEN NAME <b>EMMA HALL</b>		14. NAME OF HUSBAND OR WIFE <b>ELIZABETH ROBBERSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES W.W. # 1</b>			16. SOCIAL SECURITY NO. <b>491-05-4320</b>		17. INFORMANT Address <b>ELIZABETH ROBBERSON, SPRINGFIELD, MO.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>		
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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)				
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year						
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>6:15</u> <u>A</u> on <u>21 Oct 59</u> and last saw him live on <u>21 Oct 1959</u> . Death occurred at <u>6:15</u> <u>A</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Deceased or title) <b>Francis M. Maple MD</b>				22b. ADDRESS <b>Springfield, Mo.</b>		22c. DATE SIGNED <b>22 Oct 59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10/26/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL</b>		23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MO.</b>			
24. FUNERAL DIRECTOR <b>H.H. LOHMEYER SPRINGFIELD, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>10-23-59</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Meeter</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 12 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 Gene C. Hunter

Licensed Embalmer No. 4739

P. O. Address Sp. D. one

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.