

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036927

FILED VS OCT 23 1959

Registration District No. 12 Primary Registration District No. 578D Registrar's No. 27

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>MILLER</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>ELDON</u> Length of stay in 1b <u>24 YRS</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Highway-54-EAST</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MILLER</u> c. CITY OR TOWN <u>ELDON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Highway-54-EAST</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Ferguson</u> Last <u>Robbins</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>16</u> Year <u>1959</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>26 Sept 1870</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>16</u> Days <u>19</u>	IF UNDER 24 HR Hours <u>16</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen-Farming</u>		11. BIRTHPLACE (City and state or country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John-Wesley-Robbins</u>		13b. MOTHER'S MAIDEN NAME <u>DeLitha-Green</u>		14. NAME OF husband OR WIFE <u>Tosia-Lee-Robbins</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 <u>Opal-Porter</u> Address <u>ELDON-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>Bronchial Pneumonia</u> DUE TO (b) <u>General debility of the aged.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ 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 INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>							
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>NONE</u>			
20c. TIME OF INJURY Hour _____ Month, Day, Year <u>NONE</u>		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.) <u>NONE</u>		20f. CITY, TOWN, OR LOCATION <u>ELDON-MO</u>		COUNTY _____ STATE _____			
21. I attended the deceased from <u>4/29/59</u> to <u>10/15/59</u> and last saw him alive on <u>10/15/59</u> Death occurred at <u>1105 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Robt. E. Murrell, D.O.</u>			22b. ADDRESS <u>DO ELDON-MO</u>		22c. DATE SIGNED <u>16 Oct-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>18 Oct 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Riley-Lamn</u>		23d. LOCATION (City, town, or county) (State) <u>MILLER-Co MO</u>		
24. FUNERAL DIRECTOR <u>Keith M. Fays</u> ADDRESS <u>ELDON-MO</u>			25. DATE RECD. BY LOCAL REG. <u>OCT. 17, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Calderetta Walt</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Keith M. Kays

Licensed Embalmer No. 3998

P. O. Address Eldon Mo.

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.