

# VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-038937

FILED VS. NOV 23 1959

38

Registration District No. Primary Registration District No. 3006

Registrar's No. 556

STATE FILE NUMBER

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>Boone</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Boone</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>70 Columbia</b>		Length of stay in 1b <b>2 Wks.</b>	c. CITY OR TOWN <b>Columbia</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>703 N. 6 th St.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>703 N. 6th St.</b>		
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Robinson</b> Last			4. DATE OF DEATH Month <b>Nov.</b> Day <b>14,</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-7-1881</b>	9. AGE (last birthday) <b>78</b> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Boone County Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John A. Gibson</b>		13b. MOTHER'S MAIDEN NAME <b>Lonnie Gentry</b>		14. NAME OF HUSBAND OR WIFE <b>B. F. Robinson Dec.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>- - - - -</b>	17. INFORMANT Address <b>DeWilton Robinson, Columbia, 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>Myocardial decompensation</b>					INTERVAL BETWEEN ONSET AND DEATH <b>15 day</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Senile debility</b>						
DUE TO (c) <b>Malnutrition, emaciation</b>						
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)			
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 <b>4-29-59</b> to <b>11-13-59</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>11-13-59</b> Death occurred at <b>Columbia, Mo. 11-14-59</b> <sup>12a</sup> <sub>m</sub> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>Walter Sparks</i> (Degree or title) <b>D.O.</b>			22b. ADDRESS <b>311 Christian College Ave Columbia, Mo.</b>		22c. DATE SIGNED <b>11-16-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-16-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Columbia</b>		23d. LOCATION (City, town, or county) (State) <b>Columbia, Mo.</b>		
24. FUNERAL DIRECTOR <b>Lyman Sprinkle, Columbia, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>Nov. 16, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</b>		

(Licensed Embalmer's Statement on Reverse Side)

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

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*George P. Vannoy*

Licensed Embalmer No. 4425

P. O. Address Columbia

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.