

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030769

FILED VS SEP 6 1960

Registration District No. 149

Primary Registration District No. 1002 Registrar's No. 4287

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>	Length of stay in 1b <b>3 Weeks</b>	c. CITY OR TOWN <b>Lee's Summit</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>St Luke Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>205 So Market St.</b>

3. NAME OF DECEASED (Type or print) First <b>Lila</b> Middle <b>Lucinda</b> Last <b>Robbins</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>20</b> Year <b>1960</b>		
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/13/59</b>	9. AGE (last birthday) <b>1</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baby</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (City and state or country) <b>Kansas City Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
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13a. FATHER'S NAME <b>Cecil Robbins Jr.</b>		13b. MOTHER'S MAIDEN NAME <b>Carol Ann Downing</b>		14. NAME OF HUSBAND OR WIFE <b>*****</b>	
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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>None</b>	17. INFORMANT Address <b>Cecil Robbins Jr. Lee's Summit Mo</b>			
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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>Hydrocephalus, Congenital</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</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		
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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.)			
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year				
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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	
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21. I attended the deceased from <b>7-13-59</b> to <b>8-20-60</b> and last saw <sup>her</sup> alive on <b>8-20-60</b> Death occurred at <b>1:20</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
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22a. SIGNATURE (Degree or title) <b>Clint L. Miller MD</b>		22b. ADDRESS <b>Lee's Summit Mo.</b>		22c. DATE SIGNED <b>8/21/60</b>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8/22/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Summit Mo.</b>	23d. LOCATION (City, town, or county) <b>Lee's Summit Mo.</b>		
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24. FUNERAL DIRECTOR <b>Langsford Funeral Home</b>		ADDRESS <b>Lee's Summit Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8-21-60</b>	26. REGISTRAR'S SIGNATURE <b>H-L. Dewey</b>	
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
Clint L. Miller

**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 W. B. Langford  
Licensed Embalmer No. 3233  
P. O. Address Leis Sun

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.