

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-017948

Registration District No. 150 Primary Registration District No. 5574 Registrar's No. 42

STATE FILE NUMBER

AMENDED

FILED JUN 5 1961

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Van Buren Twp</u>              |  | Length of stay in 1b<br><u>20 yrs</u>  | c. CITY OR TOWN <u>Grain Valley</u>                                      |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Rural Colburn Rd</u> |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><u>Rural Colburn Rd</u> |
| 3. NAME OF DECEASED<br>(Type or print)   |  | First <u>Charles</u> Middle <u>B</u> Last <u>Robinson</u>  | 4. DATE OF DEATH<br>Month <u>May</u> Day <u>25</u> Year <u>1961</u>      |

|  |                                  |   |                                       |  |   |   |  |
|--|----------------------------------|---|---------------------------------------|--|---|---|--|
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec 7 1888</u> | 9. AGE (last birthday)<br><u>82</u>  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Stationary Eng</u> | 11. BIRTHPLACE (City and state or country)<br><u>Bloomfield Ark</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u> |
| 13a. FATHER'S NAME<br><u>Francis M. Robinson</u>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Mary Jane Poe</u>   |                                       | 14. NAME OF HUSBAND OR WIFE<br><u>Bervia Robinson</u>                      |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |                                       | 17. INFORMANT<br><u>Mrs Bervia Robinson</u> Address <u>Grain Valley Mo</u> |   |   |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |  | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>   |  | <u>3 days</u>                    |
| DUE TO (b) <u>Cerebral arteriosclerosis</u>  |  | <u>5 yrs.</u>                    |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
|---|--|--|--|

|   |   |  |  |
|---|---|--|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 April 2, 1960 to May 25, 1961. I last saw him alive on May 25, 1961.  
Death occurred at 2:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.

|  |  |                                    |
|--|--|------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><u>William F Bell M.D.</u> | 22b. ADDRESS<br><u>Blue Springs Mo</u> | 22c. DATE SIGNED<br><u>5-25-61</u> |
|--|--|------------------------------------|

|  |                               |   |   |
|--|-------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 23b. DATE<br><u>5/27/1961</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Blue Springs Cem</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Blue Springs Mo</u> |
|--|-------------------------------|---|---|

|  |                                   |  |   |
|--|-----------------------------------|--|---|
| 24. FUNERAL DIRECTOR<br><u>Webb Funeral Home</u> | ADDRESS<br><u>Blue Springs Mo</u> | 25. DATE RECD. BY LOCAL REG.<br><u>5/26/61</u> | 26. REGISTRAR'S SIGNATURE<br><u>W.B. Longford</u> |
|--|-----------------------------------|--|---|

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

JUN 5 1961

**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 William Free

Licensed Embalmer No. 4733

P. O. Address Blue Springs

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.