

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024181

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. \_\_\_\_\_ Registrar's No. 801

STATE FILE NUMBER

AMENDED

FILED AUG 14 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF S.E. Melaney, M.D. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Nebraska</b> b. COUNTY <b>York</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural: Marion Twp.</b>		Length of stay in 1b	c. CITY OR TOWN <b>York</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Highway #36 1 mile east of San Antonio, Mo.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>BERTIN</b> Last <b>ROBBINS</b>			4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>1961</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/23/1880</b>	9. AGE (last birthday) <b>80</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	11. BIRTHPLACE (City and state or country) <b>Nebraska</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>William Robbins</b>		13b. MOTHER'S MAIDEN NAME <b>Lida Harris</b>		14. NAME OF HUSBAND OR WIFE <b>Amy May Robbins</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>unknown</b>	17. INFORMANT Address <b>Cloyd Copper, Beaver Crossing, Nebr.</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>Crushed chest 2nd + 3rd Traumatic shock fracture cervical vertebra outside</b> DUE TO (b) <b>2 car Collision head on</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>at once</b> <b>at once</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Driver A.D. Robbins turned into wrong lane</b>			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 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.) <b>Highway 36 one mile east of San Antonio Buchanan MO</b>			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ <b>aug 5 6 1</b>	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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 _____ and last saw her _____ on <b>Aug 5-6 1</b> Death occurred at <b>7:15</b> _____ A.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>S.E. Melaney, M.D. Coroner</b>			22b. ADDRESS <b>St. Joseph 8, Mo</b>		22c. DATE SIGNED <b>aug 5 6 1</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>8/5/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph 8, Mo</b>		23d. LOCATION (City, town, or county) (State) <b>Utica Nebraska</b>	
24. FUNERAL DIRECTOR <b>Heaton-Bowman</b>		ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Aug. 7, 1961</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Handell</b>	

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**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 Spedding

Licensed Embalmer No. 4535

P. O. Address St Joseph, 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.