

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-029102

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registered District No. 318 XC-4821404 SL 13103
 Primary Registration District No. 1003 Registrar's No. 7479 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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| Rev. 4/59 |
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| AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | DATE AMENDED |
| | 9/4/62 |
| INSTEAD OF | 11/22/93 & 68 |
| | 11/14/1888 & 73 |
| SHOULD READ | 11, 13b Washington Co., Ind. & Mary Lockeneuer - Summersville, Mo. Unk. 9/4/62 |
| | 11, 13b Washington Co., Ind. & Mary Lockeneuer - Summersville, Mo. Unk. 9/4/62 |

USE BLACK INK OR TYPEWRITER RIBBON

OWN BIRTH RECORD DOCUMENT BY AFFIDAVIT OF INFORMANT

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>Jefferson</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>915 N. Grand St. Louis, Mo</u> | | Length of stay in 1b <u>80 days</u> | c. CITY OR TOWN <u>Imperial</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VET. ADM. HOSPITAL</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>RR #3</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>JESE</u> Middle <u>E.</u> Last <u>ROBISON</u> | | 4. DATE OF DEATH Month <u>JULY</u> Day <u>29</u> Year <u>1962</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 type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-22-938</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 | 9. AGE (last birthday) <u>68 73</u> |
| 11a. BIRTHPLACE (City and state or country) <u>Washington County, Indiana</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Hugh M. Robison</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unk- Mary Lockeneuer</u> | 14. NAME OF HUSBAND OR WIFE <u>Cecile J. Robison</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 7-28-17 7-9-19</u> | | 16. SOCIAL SECURITY NO. <u>Unk</u> | 17. INFORMANT <u>Cecile J. Robison Rt#3 Imperial Mo.</u> Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>CEREBRAL DYSFUNCTION</u> | | | |
| DUE TO (b) <u>CEREBRAL VASCULAR ACCIDENT</u> | | | |
| DUE TO (c) <u>331X</u> | | | |
| 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 |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>VA</u> <u>May 10, 1962</u> to <u>July 29, 1962</u> and last saw her alive on <u>July 29, 1962</u> Death occurred at <u>5:45 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u> | | 22b. ADDRESS <u>VAH, ST. LOUIS, MISSOURI</u> | 22c. DATE SIGNED <u>7-29-62</u> (State) |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <u>7-31-62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u> | 23d. LOCATION (City, town, or county) <u>St. Louis, County</u> |
| 24. FUNERAL DIRECTOR <u>Heiligttag Funeral Home, Imperial, Mo.</u> ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>JUL 30 1962</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature] M.D.</u> |

83

VS SEP 4 1962

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 J. W. M. Benkley

Licensed Embalmer No. 3683

P. O. Address St Louis 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.