

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026339

FILED VS. JUL 28 1959 / 6

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 285

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St Francois</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rt. 1 Bonne Terre, Mo.</b>		Length of stay in 1b <b>***</b>		c. CITY OR TOWN <b>Bonne Terre</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Residence, Perry Twp.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Rt. 1</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM FRANKLIN ROBBS</b>				4. DATE OF DEATH <b>July 21, 1959</b>				
5. SEX <b>Male</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>3-7-1880</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>14</b>	IF UNDER 24 HR Hours <b>4</b> Min. <b>14</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dia. Drill Oper. Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>		11. BIRTHPLACE (City and state or country) <b>Desloge, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Wm. H. Robbs</b>			13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>Belle Forshee</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war <del>name</del> and years of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>500-28-8663</b>		17. INFORMANT Address <b>Roscoe A. Robbs Bonne Terre, 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>Coronary Thrombosis</b> DUE TO (b) <b>Arterio Sclerosis Heart Disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH		
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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>April 28-59</b> to <b>July 21-59</b> last saw him alive on <b>7-10-59</b> Death occurred at <b>6:20 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Deceased or title) <b>C. H. Appukerney MD</b>				22b. ADDRESS <b>River View, Mo.</b>		22c. DATE SIGNED <b>7-20-59</b>		
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>JUL 24 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Herod Cemetery</b>		23d. LOCATION (City, town, or county) <b>Desloge, Mo.</b>		(State)		
24. FUNERAL DIRECTOR ADDRESS <b>C. Z. BOYER &amp; SON INC. Desloge, Mo.</b>				25. DATE RECD. BY LOCAL REG. OR REGISTRAR'S SIGNATURE <b>July 24, 1959 (Eather) Ruddleff</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DR. HOMER 'APPLEBERRY

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

*B. T. Boyer*

B.. T.. BOYER

Licensed Embalmer No. 3660

P. O. Address Desloge, Mo.

Note: The name 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.