

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

24592

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Lew Primary Registration District No. 1007 Registered No. _____
 City Kansas City (No. Old City Hosp) St. _____ Ward _____

2. FULL NAME

Sidney Robinson
 (a) Residence. No. 402 Main - Indep. Mo Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (circle the word) Don't know

5A. IF MARRIED, WIDOWED, OR DIVORCED - HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unk. 1885

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. about 42

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Watkins Bros.
 (Address) Kansas City, Mo

15. FILED 9/7 1927 M. M. Crowe
 REGISTRAR Arch

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-27-27

I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acicide - Firearms
173

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? ye

WHAT TEST CONFIRMED DIAGNOSIS? A autopsy

(Signed) [Signature] M. D.
 8/7/27, 19 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Blue Ridge Lawn 9/8 19 27

20. UNDERTAKER ADDRESS

Watkins Bros 1729 Lyden

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

