

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

Do not use this space.

30861
3885

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Kaw Primary Registration District No. 1002 Registered No. _____
 City Kansas City (No. 4022 Belleview St. _____ Ward)

2. FULL NAME Mrs. Kate Robinson

(a) Residence. No. 4022 Belleview St. 7 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Charles E Robinson</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 26 1842</u>		
7. AGE YEARS <u>86</u>	MONTHS <u>3</u>	DAYS <u>19</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Home</u> (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) Ireland

10. NAME OF FATHER <u>Patrick Catchford</u>
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>England</u>
12. MAIDEN NAME OF MOTHER <u>Not Known</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Not Known</u>

14. INFORMANT Mrs. J. B. Jarvis
 (Address) 4022 Belleview

15. FILED 9/15 1929 M. M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 15 1929
 17. I HEREBY CERTIFY, That I attended deceased from 14th
Sept 1929 to 14th 1929
 that I last saw her alive on 14th Sept 1929, and that
 death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Oedemia of lungs
97A
111B
162
 (duration) _____ yrs. _____ mos. 2 ds.

CONTRIBUTORY (SECONDARY) Senile conditions - Mitral insufficiency
 (duration) _____ yrs. 3 mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 900
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS none
 (Signed) Arthur W. Howell, M. D.
9/15 1929 (Address) Kansas City Mo.

*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 <u>St. Marys' Cemetery</u>	DATE OF BURIAL <u>9/16/29</u>
20. UNDERTAKER <u>Quirk & Tobin -- 20 W Linwood</u>	ADDRESS

15
8
31

PAP. M.

14

(1900)

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township X City
City City (No. St. Ward)

Registration District No. 399
Primary Registration District No. 1082

File No.
Registered No. 3885-

2. FULL NAME

(a) Residence. No. 4022 Bellevue St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 57 yrs. - mos. - ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>7</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>wid</u>
--------------------	------------------------------	--

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 26-1849

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
<u>87</u>	<u>3</u>	<u>19</u>		

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Germany
(STATE OR COUNTRY) Prussia

10. NAME OF FATHER Patrick Gallagher

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

12. MAIDEN NAME OF MOTHER Elizabeth

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

INFORMANT Mrs. T. B. Davies
(Address) 4022 Bellevue City

FILED 9/15 19 29 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 15 1929

17. I HEREBY CERTIFY That I attended deceased from Sept 15 to Sept 15, 1929 that I last saw him alive on Sept 15 and that death occurred, on the date stated above, at Sept 15 1929.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial Infarction of heart
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Pulmonary Edema
(duration) yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Home
(Signed) W. B. Davies, M. D.

(Address) 779 West 8th

*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 <u>St Marys</u>	DATE OF BURIAL <u>8/16 29</u>
---	----------------------------------

20. UNDERTAKER <u>Quinn Lobin</u>	ADDRESS <u>City</u>
--------------------------------------	------------------------

REGISTRARS SHALL RECEIVE A CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1980E-S