DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9889

Registrar's No. 1323

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No.1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Mo. & 4 days (Specify whether years, months or days)
In this community 8 Years.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: 1012 East 15th St. (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Rosalie Robinson 152
3. (b) If veteran, name war: No.
3. (c) Social Security No.: No.
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: John T. Robinson,
6. (c) Age of husband or wife if alive: 33 years
7. Birth date of deceased: Jan. 6th, 1909 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
31	2	16	hr. ____ min.

9. Birthplace: Missouri (City, town, or county) 0 (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: -------
FATHER
12. Name: Rev. J.L.Wallace
13. Birthplace: Kansas. (City, town, or county) 1 (State or foreign country)
MOTHER
14. Maiden name: No Record
15. Birthplace: No Record (City, town, or county) 6 (State or foreign country)
16. (a) Informant's own signature: John T. Robinson,
(b) Address: 1012 East 15th, Str., K.C.Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mch. 25th,40 (Month) (Day) (Year)
(c) Place: burial or cremation: Green Lawn Cemetery.
18. (a) Signature of funeral director: Mrs.C.L.Forster
(b) Address: 918 Brooklyn Avenue, K.C.Mo.
19. (a) Mch 26, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22nd year 1940 hour 9 minute 20 A.M. M.
21. I hereby certify that I attended the deceased from 2-18-40, 19__, to 3-22-40, 19__; that I last saw her alive on 3-22-40, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Generalized peritonitis
Due to: Tuberculous enteric ulcers, ruptured
Due to: 23
Other conditions: Bilateral pulmonary tuberculosis
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy: See above

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: [illegible] M.D. (M.D. or other)
Address: Supt. K.C. Gen. Hospital Date signed: 3-23-40

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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.

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 me

....., Registered Apprentice No.....,

working under my personal supervision.

Signed C. N. Wise

Licensed Embalmer No. #2570

P. O. Address K C 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 this body is not embalmed, above space should be left blank.