

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: 6840 Locust  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 19 Years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Stanley Charles Robinson  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. 487-10-4112

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Mrs. Josephine Robinson 6. (c) Age of husband or wife if alive 30 years  
 7. Birth date of deceased February 14, 1906  
(Month) (Day) (Year)

8. AGE: Years 34 Months 1 Days 25 If less than one day hr. \_\_\_\_\_ min.

9. Birthplace Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Vice-President of

11. Industry or business Community Laundry

12. Name John A. Robinson

13. Birthplace England  
(City, town, or county) (State or foreign country)

14. Maiden name Nellie Valencourt

15. Birthplace Don't Know  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. S. C. Robinson

(b) Address 6840 Locust

17. (a) Burial (b) Date thereof April 11, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Freeman Mortuary

(b) Address 104 W. 42nd St., K.C., Mo.

19. (a) April 11, 1940 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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. 6840 Locust  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9, year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 2:25 a.m. to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Punchat wound of chest

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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) DO NOT KNOW

(b) Date of occurrence 4-9-40

(c) Where did injury occur? K.C. Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? DO NOT KNOW

While at work? \_\_\_\_\_ (Specify type of place) (a) Means of injury \_\_\_\_\_

23. Signature Walter S. Hunter (M.D. or other) \_\_\_\_\_

Address K.C. Mo. Date signed \_\_\_\_\_

**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.....  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

*Clarence W. Childs*

Licensed Embalmer No.

*3473*

P. O. Address

*56 E 2nd*

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....  
 (b) Township..... Primary Registration District No..... Registered No. 1559  
 (c) City..... (d) Street No.....  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Stanley Charles Robinson

(a) Residence, No. (Usual place of abode, if no street address, write county or city) St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE ..... 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) .....

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. ....  
 9. Industry or business in which work was done, as saw mill, bank, etc. ....  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

FATHER 13. NAME .....  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

MOTHER 15. MAIDEN NAME .....  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

17. INFORMANT (ADDRESS) .....

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE .....

19. FUNERAL DIRECTOR (ADDRESS) .....

20. FILED 4/11 1940 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 9 1940

22. I HEREBY CERTIFY That I attended deceased from Agent to Coroner, 19.....  
 I last saw him alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.  
 The principal cause of death and related causes of importance were as follows:  
Suppurating wound of chest Date of onset 167

Other contributory causes of importance: .....

Name of operation ..... Date of .....  
 What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Assault Date of injury 4/7 1940  
 Where did injury occur? no (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify .....  
 (Signed) W. H. Water M. D.  
 (Address) .....

SUPPLEMENT

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

