

Registration District No. 399 Primary Registration District No. 1002

FILED DEC 11 1940

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 17 days  
(Specify whether  
In this community 37 years  
years, months or days)

3. (a) PRINT FULL NAME MINNA R. ROBINSON KISTLER

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mr. Lewis C. Kistler 6. (c) Age of husband or wife if alive ----- years

7. Birth date of deceased June 8 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
73 5 19 hr. min.

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

10. Usual occupation At Home

11. Industry or business -----

12. Name Unknown Robinson

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

14. Maiden name Samiella Shout

15. Birthplace Pennsylvania  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Margaret K. Storey

(b) Address 3015 Montgall Avenue

17. (a) Burial (b) Date thereof Nov. 29, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or crematory Mt. Washington Cemetery

18. (a) Signature of funeral director Dr. Newman's Son

(b) Address 1401 Brush Creek Blvd.

19. (a) 11-29-40 (b) M. M. Corowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limit, write "RURAL")  
(d) Street No. 3015 Montgall Avenue  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? ----- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. 27 day  
year 1940 hour 5 minute 40 P. A. M.

21. I hereby certify that I attended the deceased from  
11-10-40 19 to 11-27-40 19  
that I last saw her alive on 11-27-40 19  
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus (clinical)

Due to 59

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations  
Of autopsy

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? \_\_\_\_\_

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

23. Signature Dwight R. Shout (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

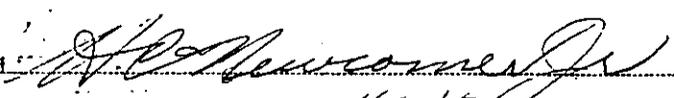
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**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



Licensed Embalmer No. 20430

P. O. Address R. P. 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.**