DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 3 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41324

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4717

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: General Hospital #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6-10-40-12-8-40 (Specify whether years, months or days)

In this community 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 2921 E. 54th St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Charles Robinson

3. (b) If veteran, name war No

3. (c) Social Security No. ~~486-03-3844~~ 486-03-3044

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Caledonia Robinson

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased 4 (Month) 11 (Day) 1890 (Year)

8. AGE: Years 50 Months 7 Days 27 If less than one day ..... hr. ..... min.

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

10. Usual occupation Mechanic

11. Industry or business Motor Inn, 11th & Oak

FATHER
12. Name John Robinson
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk

(b) Address Gen. Hosp. #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 (Month) 11 (Day) 1940 (Year)

(c) Place: burial or cremation Lincoln Cem. K.C. Mo.

18. (a) Signature of funeral director Adkins Bros.

(b) Address 2000 E. 12th

19. (a) 12-11-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 8 year 40 hour 3 minute A. M.

21. I hereby certify that I attended the deceased from 6-10- 1940, to 12-8- 1940; that I last saw him alive on 12-8- 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Broncho Pneumonia	
Due to Hypertensive Type of Heart Disease	
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)

(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 [signature] (M. D. or other)

Address Gen. Hosp. #2 Date signed 12-9-40

(Licensed Embalmer's Statement on Reverse Side)

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.

Rev. 5-17-39 I X19511

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. 9896

P. O. Address.....

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.