

Registration District No. **399**

Primary Registration District No. **1002**

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

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 and location)
(d) Length of stay: In hospital or institution **3 days**
In this community **Since May 1st 1941** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **ROBERT CORBETT**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **074-07-8705**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Clara Corbett** 6. (c) Age of ~~husband~~ wife if alive **51** years

7. Birth date of deceased **April 21 1879**
(Month) (Day) (Year)

8. AGE: Years **62** Months **3** Days **6** If less than one day hr. min.

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

10. Usual occupation **Stationary Engineer**

11. Industry or business

MOTHER FATHER { 12. Name **Unknown**
13. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name **Unknown**
15. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Clara A. Corbett**
(b) Address **2437 Cleveland**

17. (a) **Removal** (b) Date thereof **July 29 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Slater Mo.**

18. (a) Signature of funeral director **Mrs C.L. Forster**
(b) Address **918 Brooklyn**

19. (a) **7-28-41** (b) **m m Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **048**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street **2437 Cleveland** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **27th**
year **1941** hour **9** minute **15** A. M.

21. I hereby certify that I attended the deceased from **7-21-41**, 19, to **7-27-41**, 19;
that I last saw him **in** on **7-27-41**, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial failure from an old**

Due to **Coronary infarction**

Due to **94W 94W**
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy **See above**

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
23. Signature **Dr. R. How** (M. D. or other) **D**
Address **Med. Dir. K.C. Gen. Hospital** Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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 *Herzil E. Browning*
Licensed Embalmer No. *2724*
P. O. Address *H. E. ...*

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, fact should be so stated above.