

Registration District No. FILED FEB 15 1942

Primary Registration District No. 1002

1. PLACE OF DEATH: Jackson  
 (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 No. 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Lapish, Robert

3. (b) If veteran, name war no 3. (c) Social Security No. 496-03-7081

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Sept. 23 1879  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	62	3	20	_____ hr. _____ min.

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

10. Usual occupation laborer

11. Industry or business odd trades

12. Name William Lapish

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

14. Maiden name Dorothy Dixon

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

16. (a) Informant William Lapish

(b) Address Holden, Missouri

17. (a) Removal (b) Date thereof 1-13-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Holden, Missouri  
Cannaday & Kopp

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address Holden, Missouri

19. (a) 1-15-42 (b) M. M. Browne  
(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 limits, write "RURAL")  
 (d) Street No. 1408 Park  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 60 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 13th  
year 1942 hour 5 minute 35 P. M.

21. I hereby certify that I attended the deceased from 1-8-42, 19\_\_\_\_, to 1-13-42, 19\_\_\_\_; that I last saw him in alive on 1-13-42, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Cardio renal vascular disease with congestive heart failure

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

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

Other conditions 131a  
(Include pregnancy within 3 months of death)

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

Of autopsy None

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 Mary R. Thom (M. D. or other) \_\_\_\_\_

Address Med. Dir. K. G. Gen. Hospital Date signed \_\_\_\_\_

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

me

**-- 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.....

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, fact should be so stated above.**