

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9846**

FILED APR 25 1949

Primary Registration District No. **1002**

Registrar's No. **1436**

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

1. PLACE OF DEATH:
 (a) County **Jackson**
 (b) City or town **Kansas City**
 (c) Name of hospital or institution: **St. Luke's Hospital**
 (If not in hospital or institution, write street number or location) **0**
 (d) Length of stay: In hospital or institution **11 Hours**
 In this community **11 Hours**
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Saline** **099**
 (c) City or town **Marshall** **1**
 (If outside city or town limits, write "RURAL") **2**
 (d) Street No. **338 East Varby St.**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country **1**

3. (a) PRINT FULL NAME **John M. Robertson**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **April** day **10**
 year **1942** hour **1** minute **30** **A.M.**

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Mrs. Belle Harrison Robertson**
 6. (c) Age of husband or wife if alive **16** years

21. I hereby certify that I attended the deceased from **Apr 2 9**
1942, to **Apr 10**, 19**42**
 that I last saw him alive on **Apr 10**, 19**42**
 and that death occurred on the date and hour stated above.

7. Birth date of deceased: **September 16 1854**
 (Month) (Day) (Year)
 8. AGE: Years **87** Months **6** Days **24**
 If less than one day hr. min.

Immediate cause of death:
Haemorrhage in Cerebellum & brain
 Due to **with rupture into Venous**
 Due to **arteriosclerosis**

9. Birthplace **Edina Missouri**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **Retired**
 11. Industry or business **Farmer**

Other conditions (include pregnancy within 3 months of death) **830**
 Major findings: Of operations
 Of autopsy **Glucose cerebellum**
Haemorrhage - rupture -

MOTHER FATHER {
 12. Name **Albert G. Robertson**
 13. Birthplace **Crawford County, Ohio**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Mary Black** **Ohio**
 15. Birthplace (City, town, or county) (State or foreign country)

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 **1**

16. (a) Informant **Albert G. Robertson**
 (b) Address **Malta Bend, Missouri**
 17. (a) **Removal** (b) Date thereof **4-10-42**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Marshall, Missouri**
 18. (a) Signature of funeral director **J. W. Wagner**
 (b) Address **Kansas City, Missouri**
 19. (a) **4-10-42** (b) **M. M. Brown**
 (Date received local registrar) (Registrar's signature)

23. Signature **J. W. Wagner** (M. D. or other)
 Address **1132 W. Harrison St. Marshall, Mo.**

MAR 6 1944

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 A. R. Harnscheidt
Licensed Embalmer No. 4159
P. O. Address K. E. 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, fact should be so stated above.