

S. No. 2
M-5-42
v. 5-17-39
I X32873

32936

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **3841**

Filed NOV 9 1942 149

Registration District No. _____ 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

(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 1 day (Specify whether)

In this community 16 year years, months or days

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. 7511 Main St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Rex Robertson

3. (b) If veteran, name war No

3. (c) Social Security No. 495-03-0703

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 14th year 1942 hour 8 minute 55 P.A.M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Madge L. Robertson 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased Sept 21 1903
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 10-13-42 19 to 10-14-42 19 that I last saw him alive on 10-14-42 19 and that death occurred on the date and hour stated above.

8. AGE: Years 39 Months 0 Days 13 If less than one day hr. min.

Immediate cause of death Cause of death not determined—diagnosis deferred pending microscopic study by Pathological Department of Hospital

Due to Acute & Chronic Alcoholism

Due to Mild meningeal edema

Hepatic insufficiency

Other conditions Pneumo pneumonia
(Include pregnancy within 3 months of death)

9. Birthplace Los Angeles California
(City, town, or county) (State or foreign country)

10. Usual occupation Line of type

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy See above

Underline the cause to which death should be charged statistically.

MOTHER, FATHER {

12. Name Carlisle Robertson

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

14. Maiden name Lois Belle Miller

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

16. (a) Informant Mrs. Madge Robertson

(b) Address 7511 Main

17. (a) Removal (b) Date thereof 10-18-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eagleville, Mo

18. (a) Signature of funeral director H. J. Brown

(b) Address 76 Cass St. Mo

19. (a) 10-18-42 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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) Means of injury _____

23. Signature Anney R. Brown (M. D. or other) _____
Address Med. Dir. K. C. General Hospital Date signed _____

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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... *Clarence W. Chiles*
Licensed Embalmer No. *3423*
P. O. Address... *716 E. Meo*

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.