

Registration District No. FILED JAN 25 1942

Primary Registration District No. 1001-1000

1. PLACE OF DEATH:
(a) County BUCHANAN
(b) City or town ST. JOSEPH
(c) Name of hospital or institution: State Hospital No. 2
(d) Length of stay: In hospital or institution 13 yrs 1 mo 2 days
In this community 13 years 1 mo 27 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. Unknown
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME June Robinson
3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 11 year 1943 hour 2:50 minute _____ A. M.
21. I hereby certify that I attended the deceased from December 4 1942 to January 11 1943
that I last saw her alive on January 10 1943
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown
7. Birth date of deceased: _____ (Month) _____ (Day) 1890 (Year)

Immediate cause of death Acute congested heart failure Duration _____

8. AGE: Years 52 Months - Days - If less than one day _____ hr. _____ min.

Due to Chronic Myo-cardial disease

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

Due to _____

10. Usual occupation Cashier in Cafe

Other conditions (Include pregnancy within 3 months of death) 930

11. Industry or business _____
12. Name Unknown
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

PHYSICIAN _____
Major findings: Of operations _____
Of autopsy Acute congested heart failure
Chronic Myo-cardial disease

16. (a) Informant My Thompson 683 Washington
(b) Address Drop Line, Mass.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-43 (Month) (Day) (Year)
(c) Place: burial or cremation Hospital Cemetery

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? _____

18. (a) Signature of funeral director Wm. Garry
(b) Address 218 South 10th St. J.
19. (a) 1-18-43 (Date received local registrar) (b) Rose Hegag (Registrar's signature)

While at work _____ (Specify type of place) (c) Means of injury _____
23. Signature RB Jureary (M. D. or other MD)
Address State Hosp. # 1 Date signed 1-12-43

1233

(Licensed Embalmer's Statement on Reverse Side)

State Joseph, Mo.

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

MOTHER FATHER

Was not embalmed

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.