

FILED NOV 9 1943

Registration District No. **2**

Primary Registration District No. **1000**

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

1. PLACE OF DEATH:

(a) County **Buchanan**  
(b) City or town **Saint Joseph**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Missouri Methodist Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **30 days**  
In this community **Ten years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Joseph Newton Robinett**

3. (b) If veteran, name war. \_\_\_\_\_ 3. (c) Social Security No. **NONE**

4. Sex **Male** 5. Color or Race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Mrs. Bertha Robinette** 6. (c) Age of husband or wife if alive **66** years  
7. Birth date of deceased **January 1, 1870**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**73 9 12** hr. min.

9. Birthplace **Atchison County, Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Richard Robinett**  
13. Birthplace **Unknown Indiana**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Demaris Lytele**  
15. Birthplace **Unknown Indiana**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Richard Robinett**

(b) Address **1722 Capital, Omaha, Nebr.**

17. (a) **Burial** (b) Date thereof **Oct. 13, 1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Auburn Cemetery**

18. (a) Signature of funeral director **Mr. E. R. Giden**  
(b) Address **602 South 10th Street, St. Joseph**

19. (a) **10-13-43** (b) **Rae H. Hays**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**  
(c) City or town **Saint Joseph**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1004 So. 11th Street**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **12**  
year **1943** hour **6** minute **40 A.M.**

21. I hereby certify that I attended the deceased from **September 12th**, 1943, to **October 11**, 1943;  
that I last saw him alive on **October 11**, 1943;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

*Chronic Myocarditis over 30 days*

*Chronic nephritis over 30 days*

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN  
Major findings: **1316**  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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) (c) Means of injury \_\_\_\_\_

23. Signature **Deeley** (M. D. or other) \_\_\_\_\_  
Address **St. Joseph, Mo** Date signed **10/13/43**

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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

*Mollie E. Sidenfaden* *Tr*

Licensed Embalmer No.

*4235*

P. O. Address

*St. Joseph 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.**