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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14841

FILED MAY 9 1944
Registration District No. 176

Primary Registration District No. 5568

Registrar's No. 82

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Rural Blue Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
226 South Cedar
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 30 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Rural Blue 41
(If outside city or town limits, write "RURAL")
(d) Street No. 226 South Cedar
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME OSCAR W. ROBINSON
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 1st,
year 1944 hour 10 minute 30 A.M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Jessie Robinson 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased August 13th, 1874
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec. 18,
1943 to April 1, 1944
that I last saw him alive on March, 1944
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
69 7 18 hr. _____ min.

Immediate cause of death Coronary Occlusion
Due to Generalized Arteriosclerosis
Due to _____

9. Birthplace St. Paul, Minnesota
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: 94a
Of operations _____
Of autopsy _____

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER
12. Name George W. Robinson
13. Birthplace St Paul, Kansas
(City, town, or county) (State or foreign country)
14. Maiden name Eliza Huggins
15. Birthplace No Data
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Jessie Robinson
(b) Address 226 S. Cedar Kansas City, Mo
17. (a) ~~Burial Removal~~ (b) Date thereof 4/6/44
(Burial, cremation, or removal) (Month) (Day) (Year)

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 _____

(c) Place: burial or cremation Trading Post, Kansas
18. (a) Signature of funeral director Robert R. Apacher
(b) Address Independence, Missouri
19. (a) 4-4-1944 (b) Danew Rose
(Date received local registrar) (Registrar's signature)

23. Signature Chas. E. Nickerson, M.D. (M.D. or other)
Address Independence, Mo Date signed 4-3-44

1163 (Licensed Embalmer's Statement on Reverse Side)

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

JUL 19 1948

MAY 17 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.....

.....
working under my personal supervision.

.....
Registered Apprentice No.

Signed

Roland P. Sparks

.....
Licensed Embalmer No. *3604*

.....
P. O. Address *Indep. 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. M 44
Registrar's No. 82

Registration District No. 146 Primary Registration District No. 5568

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Blue
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Oscar W. Robinson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 13 1899
(Month) (Day) (Year)

8. AGE: Years 69 Months 7 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business Ford Motor Co.

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 5/19/44 (b) James W. Ross
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

Jan 11 1882

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