

FILED OCT 5/1944
Registration District No. _____

Primary Registration District No. 1000

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town Saint Joseph Hospital
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Saint Joseph HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community Since 1929
years, months or days)

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. 102 1/2 North 2nd street
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joseph Robinson
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 single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Unknown 1872
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>unk</u>	<u>unk</u>	hr. _____ min. _____

9. Birthplace New York city New York
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER
12. Name Unknown Robinson
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown UNKNOWN
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Welfare Board Records

(b) Address 10th & Olive Street

17. (a) Burial (b) Date thereof Sept. 2, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Mr. E. P. SIDENFADEN

(b) Address 602 South 10th Street

19. (a) 9-2-44 (b) Nelen J. Pickett
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month September 1st
year 1944 hour 11 minut 30 P. M.

21. I hereby certify that I attended the deceased from Sept 1
1944 to Sept 1 1944
that I last saw alive on Sept 1 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of stomach
Duration 3

Due to _____

Due to _____

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

Major findings:
Of operations NO

Of autopsy _____

PHYSICIAN
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)
(e) Means of injury _____

23. Signature T. L. Howden (M. D. or other) NO

Address 602 Olive Street Date signed 9-2-44

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. Sideman*

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.