

S. No. 2
M-5-43
v. 5-17-39
1 X36671

State File No.

FILED NOV 7 1945

Registration District No. 187

Primary Registration District No. 1002

Registrar's No. 4419

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
635 Romany Road /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 40 years (Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson #8

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1909 Highland
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert Lockhart

3. (b) If veteran, name war None

3. (c) Social Security No. none

4. Sex Male

5. Color or race Col

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

6. (b) Name of husband or wife Emma Lockhart

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased August 10 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	67	2	15/14	hr. min.

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

10. Usual occupation Cement Finisher

11. Industry or business Self

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Emma Lockhart

(b) Address 1909 Highland

17. (a) burial (b) Date thereof 10/27/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director Hatkins Bros

(b) Address 1729 Lydia

19. (a) 10-27-45 (b) St. Pauline Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 24
year 1945 hour 3:30 minute P. M.

21. I hereby certify that I attended the deceased from 10/24/45 to 10/24/45 that I last saw Deputy Coroner alive on 10/24/45 and that death occurred on the date and hour stated above.

Immediate cause of death Mitral insufficiency
Endocarditis chronic
Chronic Nephritis

Due to _____

Due to _____

Other conditions 131/15
(Include pregnancy within 3 months of death)

Major findings: 131/15

Of operations _____

Of autopsy Mitral insufficiency
Endocarditis & Nephritis

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? K.C. Jackson Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
635 - Romany Rd.
(Specify type of place) (e) Means of injury _____

While at work? yes

Signature W. Williams (M.D. or other) Deputy Coroner

Address 2136 - Brooklyn Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

361

(Licensed Embalmer's Statement on Reverse Side)

10-27-45

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 _____

J. Manlove

Licensed Embalmer No. _____

3994

P. O. Address _____

2503 Highland

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.