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5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

State File No. 33236

FILED NOV 1 1945 STANDARD CERTIFICATE OF DEATH 1000

Registrar's No. 1140

Registration District No. 42 Primary Registration District No.

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: 817 North 2nd St.  
(If not in hospital or institution, write street number or location)

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

3. (a) PRINT FULL NAME Harry Robinson

3. (b) If veteran, name war none

3. (c) Social Security No. 355-03-2542

4. male 5. Color or race col. 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Nettie Robinson 6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased June 1st 1914  
(Month) (Day) (Year)

8. AGE: Years 31 Months 4 Days 29 If less than one day hr. min.

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

10. Usual occupation none

11. Industry or business none

12. Name Patrick Robinson

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

14. Maiden name Mary B. Robinson

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

16. (a) Informant Nettie Robinson

(b) Address 817 North 2nd St.

17. (a) burial (b) Date thereof 10 23 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Paulsey & Sons

(b) Address 1602 Mesquite

19. (a) 10/25-1945 (b) H. Robinson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 817 North 2nd St.  
(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 20  
year 1945 hour 12 minute 10 A.M.

21. I hereby certify that I attended the deceased from Oct 12 1945 to Oct 19 1945  
that I last saw him alive on Oct 19 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 10 days

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_

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 \_\_\_\_\_

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 J. R. D. Crossland (M. D. or other) M.D.  
Address 779 S. 24 Date signed 10-22-45

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

MOTHER FATHER

1428

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

FILED  
NOV 1 1945

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. F. Ramsey*.....  
Licensed Embalmer No. *4081*.....  
P. O. Address. *1607 Messaris*.....

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.

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St Joseph  
(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 Harry Robinson

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

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

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

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.)

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

10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 817 North 2nd St.  
(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 1945 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Oct. 9<sup>th</sup> to Oct. 10<sup>th</sup> 1945 and that death occurred on the date and hour stated above.  
Immediate cause of death Pneumonia  
tabac

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

ADDITIONAL SUPPLEMENTARY INFORMATION  
Major findings: Of operations \_\_\_\_\_  
Of autopsy 108

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 J.R. Crossland (M. D. or other) \_\_\_\_\_

Address 720 S. 24 Date signed Oct 22-45

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

SUPPLEMENTARY

1957 APR 25 10 10 AM  
FBI - NEW YORK

33236