

**FILED FEB 7 1946**  
Registration District No. **148**

Primary Registration District No. **1002**

Registrar's No. **340**

**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: **General Hospital #2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **23 days**  
(Specify whether  
In this community **67 yrs.**  
years, months or days)

3. (a) PRINT FULL NAME **Robert Waldron**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **48709-6162A**

4. Sex **Male** 5. Color or race **Negro**  
6. (a) Single, widowed, married, divorced **Married**  
6. (c) Age of husband or wife if alive **61** years  
7. Birth date of deceased **February 13, 1878**  
(Month) (Day) (Year)

8. AGE: Years **67** Months **11** Days **6**  
If less than one day  
hr. min.

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

10. Usual occupation **None Laborer**

11. Industry or business **None**

MOTHER FATHER  
12. Name **Elijah Waldron**  
13. Birthplace **Virginia**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Flora**  
15. Birthplace **unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Medical Records Librarian**

(b) Address **General Hospital #2**

17. (a) **Burial** (b) Date thereof **1 22 46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Highland Cemetery**

18. (a) Signature of funeral director **[Signature]**  
(b) Address **1729 Lytle Ave. S. C. Mo.**

19. (a) **1-21-46** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **2011 E. 24th Terrace**  
(If rural, give location)  
(e) Citizen of foreign country? **No**  
If yes, name country

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **January** day **19**,  
year **1946** hour **1** minute **40 A.** M.

21. I hereby certify that I attended the deceased from **December 27, 1945** to **January 19, 1946**

that I last saw him alive on **January 19, 1946**

and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Heart Disease and Arteriosclerotic Heart disease** Duration

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

(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) Means of injury

23. Signature **[Signature]** (If D. on other)

Address **General Hospital #2** Date signed **1/19/46**

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

1307

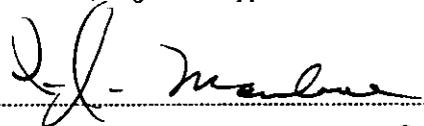
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**STATEMENT BY LICENSED EMBALMER**

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..... 

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.**