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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAY 20 1946**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16684

State File No. ....

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2103

1. PLACE OF DEATH:

(a) County JACKSON  
(b) City or town KANSAS CITY, MO  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
FAIRMOUNT HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 WKS  
(Specify whether  
In this community 2 WKS  
years, months or days)

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. 1414 East 27  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country .....

3. (a) PRINT FULL NAME ROBERT JOE HENDERSON

3. (b) If veteran, name war V no 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 X 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased APR 21 1946  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
14 hr. min.

9. Birthplace KANSAS CITY MO  
(City, town, or county) (State or foreign country)

10. Usual occupation X infant

11. Industry or business X

12. Name HAROLD ARXINT  
13. Birthplace KANSAS  
(City, town, or county) (State or foreign country)

14. Maiden name JOANNE HENDERSON  
15. Birthplace FORT SCOTT KANS.  
(City, town, or county) (State or foreign country)

16. (a) Informant FAIRMOUNT HOSPITAL  
(b) Address 1414 E 27

17. (a) Burial (b) Date thereof May 10 46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director A. P. Doshler  
(b) Address 1415 East 15

19. (a) 5-9-46 (b) Staldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5  
year 1946 hour 7 minute 20 A. M.

21. I hereby certify that I attended the deceased from APRIL 21  
1946 to MAY 5, 1946;

that I last saw him alive on MAY 4, 1946;  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia - con

Due to Congenital defective bladder & obstruction of urethra  
Due to .....

Other conditions Patent urachus  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations 157 hr  
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? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? .....

23. Signature [Signature] (M. D. number)  
Address 510 [Address] Date signed 5/6/46

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

15566

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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.....

P. O. Address.....

**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.**