

S. No. 2
OM-5-43
v. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16819

State File No.

FILED MAY 20 1946

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2119

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 No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days
(Specify whether years, months or days)

In this community 3 years

3. (a) PRINT FULL NAME William¹ Robinette

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 5. Color or race w

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

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

6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased Feb 24 1867
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>2</u>	<u>16</u>	hr. min.

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

10. Usual occupation farming.

11. Industry or business

12. Name Mrs. Robinette

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

14. Maiden name Haney Witt

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

16. (a) Informant Hospital Records.

(b) Address Kansas City Mo.

17. (a) Removal (b) Date thereof 5-10-46.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawson Mo.

18. (a) Signature of funeral director J. W. Morrow

(b) Address Lawson Mo.

19. (a) 5-10-46 (b) Geraldine Holmes
(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. 810 W. 46
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10
year 1946 hour 7 minute 35 A.M.

21. I hereby certify that I attended the deceased from April 26, 1946 to May 10, 1946
that I last saw him alive on May 10, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia, left; Chronic emphysema, right with atelectasis of right lung

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 108

Of autopsy See above

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

Signature Wm W. Hart (M. D.) 5-10-46
Address Med. Dir. Gen'l Hosp. Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

15653

In Business

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 *Joe A. Moles*
Licensed Embalmer No. *3296*
P. O. Address *Ex Springs 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.