

FILED JUL 9 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 1000

Registrar's No. 680

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph Mo  
(c) Name of hospital or institution: Mrs. Della McKeen Rest Home, 1313 N. 10th  
(d) Length of stay: In hospital or institution 7 days  
In this community 7 days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Buchanan  
(c) City or town Gower  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Frank Robertson

3. (b) If veteran, name war No. \_\_\_\_\_  
3. (c) Social Security No. 499-14-434

4. Sex M Color or race W  
5. Color or race W  
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Marie Robertson  
6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Jan 10th 1873

8. AGE: Years 73 Months 5 Days 2  
If less than one day hr. min.

9. Birthplace Coffeyville Kansas

10. Usual occupation C. D. K.

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

MOTHER FATHER

12. Name Jim Robertson

13. Birthplace Kentucky

14. Maiden name Elizabeth Tritt

15. Birthplace Virginia

16. (a) Informant Mrs. Ida Robertson

(b) Address Gower Mo

17. (a) Burial (b) Date thereof 6/14/46

(c) Place: burial or cremation Allen C. E. M.

18. (a) Signature of funeral director H. A. Sullins

(b) Address G. O. W. E. R. Mo  
19. (a) June 12, 1946 (b) \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 12th  
year 1946 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from 2-11-1946 to 6-6-1946

that I last saw him alive on 5-29-1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis

Due to Arterio Sclerosis Coronary Arteriosclerosis

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 97

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. C. Starnes (M. D. or other) MD.  
Address \_\_\_\_\_ Date signed 6-12-46

Duration

Death within 24 hours

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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 H. A. Sullins

Licensed Embalmer No. 1738

P. O. Address Lawson 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.**