

No. 2  
-12-45  
5-17-39  
I X47030

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9354**  
Registrar's No. **1373**

**FILED APR 8 1947**

Registration District No. 197

Primary Registration District No. 1002

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:  
Montague Hotel 1 112 W. 11 st 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 1 1/2 yrs (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. 5438 E. 11 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 3 day 21  
year 1947 hour 2 1/2 minute 1 M.  
21. I hereby certify that I attended the deceased from evening 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Duration

Other conditions (Include pregnancy within 3 months of death) g3a  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy as above

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? \_\_\_\_\_

(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury 3  
23. Signature John C. Walker (M. D. or other) \_\_\_\_\_  
Address 7424 Olive St. Date signed 3-22-47

3. (a) PRINT FULL NAME Carmen Sylvia Robinson

3. (b) If veteran, name war no 3. (c) Social Security No. 489-21-4600

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

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

7. Birth date of deceased: December 26 1900  
(Month) (Day) (Year)

8. AGE: Years 46 Months 2 Days 24 1/2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name A. J. Trayler

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

14. Maiden name Mary Bailey

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

16. (a) Informant L. D. Robinson

(b) Address 5438 E. 11 st, K.C. MO

17. (a) Burial (b) Date thereof Mar 24 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt. Washington

18. (a) Signature of funeral director C. H. Blackburn

(b) Address Kansas City, Mo

19. (a) 3-24-47 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

**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 Q. K. McFarland  
Licensed Embalmer No. 4397  
P. O. Address Kansas City, 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.**