

No. 2  
-12-45  
5-17-39  
X47070

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **17590**  
Registrar's No. **2139**

FILED MAY 26 1947

Registration District No. 149

Primary Registration District No. 1002

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

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. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12 DAYS  
(Specify whether  
In this community unknown  
years, months or days)

3. (a) PRINT FULL NAME JAMES ROBINSON

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex MALE 2 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife LILLIAN ROBINSON 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased. unknown  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
app. 70 hr. min.

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

10. Usual occupation none

11. Industry or business

MOTHER FATHER  
12. Name JOHN ROBINSON  
13. Birthplace TENNESSEE  
(City, town, or county) (State or foreign country)  
14. Maiden name LUCINDA  
15. Birthplace TENNESSEE  
(City, town, or county) (State or foreign country)

16. (a) Informant STEVE KERFORD (FRIEND)

(b) Address 2300 PASEO

17. (a) Removal (b) Date thereof 5-15-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K.C. University

18. (a) Signature of funeral director H.B. Mansy

(b) Address 1820 E 18th

19. (a) 5-14-47 (b) Alfredine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48  
(c) City or town KANSAS CITY 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2300 PASEO 8  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 25,  
year 1947 hour 12: minute 30 A.M.

21. I hereby certify that I attended the deceased from APRIL  
13, 1947 to APRIL 25, 1947;  
that I last saw h. IM alive on APRIL 25, 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death HYPERTENSIVE HEART  
DISEASE WITH CARDIAC FAILURE

Due to GENERALIZED ARTERIOSCLEROSIS

Due to

Other conditions LATENT SYPHILIS  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations 30g  
Of autopsy

Duration  
Underline the cause to which death should be charged statistically.  
PHYSICIAN

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 J

23. Signature Frank (M. D. or other) M. D.  
Address GENERAL HOSPITAL NO. 2 Date signed 4/25/47

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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.....

*A B Moore*

Licensed Embalmer No. *2410*

P. O. Address. *1820 E 18 St*

**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.**