

No. 2
-5-43
-17-39
X36671

FILED NOV 4 1948
Registration District No. **779**

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:
Osteopathic Hospital D
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9-19-48
to 10-16-48 Specify whether

In this community see above
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County EIK 999

(c) City or town Howard
(If outside city or town limits, write "RURAL")

(d) Street No. Rout # 2
(If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME George Michael Robinson

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male D 5. Color or race W.

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

6. (b) Name of husband or wife Maud

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

7. Birth date of deceased March 6 1883
(Month) (Day) (Year)

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

65 7 13 10 hr. min.

9. Birthplace Fall River Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name James E. Robinson

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

14. Maiden name Sarah Collier

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

16. (a) Informant Howard Robinson

(b) Address Howard Kansas

17. (a) Removal (b) Date thereof 10-17-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Howard, Kansas

18. (a) Signature of funeral director Miss Funeral Home

(b) Address Howard, Kansas

19. (a) 10-16-48 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 16
year 49 hour 1 minute 05 P.M.

21. I hereby certify that I attended the deceased from 9-19
1948 to 10-16 1948

that I last saw h. ma. alive on 10-16 1948
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial failure Duration _____

Due to lobar pneumonia

Due to ancient fracture of lumbar vertebrae

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 108

Of operations _____

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) Auto accident Hwy

(b) Date of occurrence July 29 1947

(c) Where did injury occur? at Fall River Ka.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on their farm

While at work? yes. (Specify type of place) Accident

Signature T. T. McGrath (M. D. or other) DD
Address 1727 Ind. Ave. Date signed 10-16-48

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... *Augustus C. Werner*
Licensed Embalmer No. *2597*
P. O. Address... *Kansas City, Kansas*

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.)

FAIRWEATHER WERNER

If this body is not embalmed, fact should be so stated above.

MONSIEUR *Dr 322*