

FILED FEB 9 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1606  
95  
Registrar's No. 1002

BIRTH NO. 48615 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph 0117-1</b>                                       |  |
| c. LENGTH OF STAY (in this place) <b>5 mo 2 da</b>  |  | d. STREET ADDRESS (If rural, give location) <b>1804 S 28<sup>th</sup> / X</b>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>                               |  |   |  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 3. NAME OF DECEASED<br>a. (First) <b>KATHY</b> b. (Middle) <b>LYNNE</b> c. (Last) <b>ROBERTSON</b>        |  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>1 8 53</b> |   |  |
| 5. SEX <b>female</b>  |  | 6. COLOR OR RACE <b>white</b>            |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never married</b> |  |
| 8. DATE OF BIRTH <b>Aug 6 1952</b>  |  | 9. AGE (In years last birthday) <b>5</b> |  | 10. MONTHS <b>2</b> HOURS <b>1</b> MIN. <b>0</b>                            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY        |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>MO 0 1</b>            |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  |  |  |  |   |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 13a. FATHER'S NAME <b>William E. Robertson</b>                              |  | 13b. MOTHER'S MAIDEN NAME <b>Virginia N. Flashman</b> |  | 14. NAME OF HUSBAND OR WIFE <b>none</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> |  | 16. SOCIAL SECURITY NO. <b>none</b>                   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>W. E. Robertson 1804 S 28<sup>th</sup> St. St. Joseph Mo</b> |  |

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congenital Heart Disease with Multiple Defects.</b>   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><b>75 1/4</b> |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Bilateral cleft palate &amp; hare lip</b> |  |  |   |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION                          |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)        |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)                                  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 22a. SIGNATURE <b>David M. Gibson</b> (Degree or title) <b>M.D. (Pathologist)</b> |  | 22b. ADDRESS <b>St. Luke's Hospital K.C. Mo.</b>               |  | 22c. DATE SIGNED <b>1/9/53</b>                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>                           |  | 23b. DATE <b>1-10-1953</b>                                     |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn</b> |  |
| 23d. LOCATION (City, town, or county) (State) <b>St. Joseph Mo</b>                |  | 23e. FUNERAL DIRECTOR'S SIGNATURE <b>Geraldine Smith Breit</b> |  | 23f. ADDRESS <b>Funeral Home Savannah Mo</b>           |  |
| 24a. DATE REC'D BY LOCAL REG. <b>1-9-53</b>                                       |  | 24b. REGISTRAR'S SIGNATURE                                     |  | 24c. NAME OF CEMETERY OR CREMATORY                     |  |

(Licensed Embalmer's Statement on Reverse Side)

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

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah 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.