

health, Welfare Public Service  
 300 1-56  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUL 25 1956

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

239930  
 STATE FILE NUMBER 2942

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Independence</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) <b>St. Marys Hospital</b>			Length of stay in lb <b>1 day</b>	d. STREET ADDRESS (If outside, give location) <b>2722 Westport</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Robert R. Rinacke</b>				First	Middle	Last	4. DATE OF DEATH <b>July 4, 1956</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1902</b>		9. AGE (In years last birthday) <b>54</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plant Supervisor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Chevrolet Div.</b>		11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Frank Rinacke</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Carter</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>487 09 3941</b>		17. INFORMANT <b>Mrs. Edna M. E. Rinacke, Independence, Mo.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Longiation Fibrosis of lungs</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>X Ray therapy</b>		DUE TO (c) <b>Cancer of the right nodule left larynx</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>10:30A</b> a. m. p. m.										
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Independence</b>		COUNTY <b>Jackson</b>		STATE <b>Missouri</b>		
21. I attended the deceased from <b>7-3-56</b> to <b>7-4-56</b> and last saw her/him alive on <b>7-4-56</b> . Death occurred at <b>10:30A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <b>John H. Mayer</b> (Degree or title) <b>MD</b>				22b. ADDRESS <b>4620 Jc Nickel Pkwy</b>			22c. DATE SIGNED <b>7/6/56</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/7/56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington Cem.</b>			23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>				
24. FUNERAL DIRECTOR <b>Geo. C. Gerson</b>			ADDRESS <b>Independence, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>7-6-56</b>		26. REGISTRAR'S SIGNATURE <b>neva minshall</b>			

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed..... Tom D. Marblan

Licensed Embalmer No. 459

P. O. Address. Indep

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitute's grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.