

Health, Welfare, Public Service, 0, 300, 1-56, All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34204

STATE FILE NUMBER

FILED OCT 24 1956

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4322

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARY'S HOSPITAL</u>			Length of stay in 1b <u>4 yrs</u>		STREET ADDRESS (If outside, give location) <u>431 W. 46th. Terr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>VETA</u> Middle <u></u> Last <u>ROBBINS</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB-4-1885</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER &amp; SUPERVISOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME ECONOMICS</u>		11. BIRTHPLACE (City and state or country) <u>RUSSELL, KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. H. FRANKLIN</u>				14. MOTHER'S MAIDEN NAME <u>IRENE HUGGINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>CHARLES FRANKLIN ROBBINS 431 WEST 46TH TERR KANSAS CITY, MO.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>4200</u>
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 <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>							
20d. INJURY OCCURRED WHILE AT <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		COUNTY	STATE
21. I attended the deceased from <u>9-22-56</u> to <u>10-1-56</u> and last saw her <u>him</u> alive on <u>10-1-56</u> . Death occurred at <u>8:45 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Richard E. Davis M.D.</u> (Degree or title)				22b. ADDRESS <u>4440 West 71st Prairie Village, Mo.</u>		22c. DATE SIGNED <u>10-3-56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>OCT-4-1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u></u>		23d. LOCATION (City, town, or county) (State) <u>ARDMORE OKLAHOMA</u>		
24. FUNERAL DIRECTOR ADDRESS <u>D.W. NEWCOVER SONS 1331 BRUSH CREEK KANSAS CITY, MO.</u>			25. DATE RECD. BY LOCAL REG. <u>10-4-56</u>		26. REGISTRAR'S SIGNATURE <u>Mona Minshall</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Richard E. Davis, M.D.

4140 W 71 St

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 *Richard L. Rogers* .....

Licensed Embalmer No. *49* .....

P. O. Address *K. L. D.* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes 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.