

Health,  
Welfare  
Public  
Service

FILED APR 29 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5289

STATE FILE NUMBER  
12510

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 33

300  
1-57  
600

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>CLAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>CLAY</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>NORTH KANSAS CITY - RURAL</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>RURAL - NORTH KANSAS CITY</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>R.R.#12</b> Length of stay in 1b <b>1 YEAR</b>		d. STREET ADDRESS (If outside, give location) <b>R.R.#12</b> 600 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALBERT HOLBY ROBINSON</b>			4. DATE OF DEATH Month Day Year <b>APRIL - 13 - 1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 22 - 1868</b>
9. AGE (In years last birthday) <b>89</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>	11. BIRTHPLACE (City and state or country) <b>CINCINNATI, OHIO</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>UNKNOWN ROBINSON</b>	13b. MOTHER'S MAIDEN NAME <b>MARY UNKNOWN</b>
14. NAME OF HUSBAND OR WIFE <b>MRS. FLORENCE ROBINSON</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>NONE</b>
17. INFORMANT <b>JESSE A. ROBINSON</b> Address <b>R.R.#12 NORTH KANSAS CITY 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>Arteriosclerotic Heart Disease &amp; myocardial infarction of congestive failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4200</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year a.m. p.m.		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 <b>July 1956</b> to <b>April 1957</b> and last saw her/him alive on <b>4-11-57</b> Death occurred at <b>6:00 a.m.</b> of the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>David J. Zacharias, M.D.</b>		22b. ADDRESS <b>6644 North Oak</b>	
22c. DATE SIGNED <b>4-13-57</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
23b. DATE <b>APR. 13 - 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANDERSON CEMETERY</b>	
23d. LOCATION (City, town, or county) (State) <b>ANDERSON MISSOURI</b>		24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b> ADDRESS <b>1331 BRUSH CREEK KANSAS CITY MO</b>	
25. DATE RECD. BY LOCAL REG. <b>4-13-57</b>		26. REGISTRAR'S SIGNATURE <b>Marguerite Hudgens</b>	

(Licensed Embalmer's Statement on Reverse Side)

+94



MAY 1 1957

### 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 Chester K. Braun

Licensed Embalmer No. 4831

P. O. Address KE 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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