Health, Welfare Public Service

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FILED SEP 19 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

32136
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4042

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) KANSAS CITY — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) VA HOSPITAL — Length of stay in 1b 26 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE KANSAS b. COUNTY Wyandotte
c. CITY OR TOWN KANSAS CITY — Inside Limits Yes [ ] No [ ]
X d. STREET ADDRESS (If outside, give location) 1707 RICHMOND — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First CASPER Middle WILLIAM Last ROBBECKE

4. DATE OF DEATH Month Day Year August 28, 1957

5. SEX Male
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH August 22, 1911
9. AGE (In years last birthday) 46 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (City and state or country) Detroit Lakes Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Walter Robbecke
13b. MOTHER'S MAIDEN NAME Grace Kennedy
14. NAME OF HUSBAND OR WIFE Myrtle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII
16. SOCIAL SECURITY NO. 472 01 4190
17. INFORMANT Address VA Hospital Official Records, K. C. Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Inanition; pulmonary congestion and edema
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) Previously irradiated carcinoma nasopharynx with metastases to ribs vertebrae, lymph nodes
INTERVAL BETWEEN ONSET AND DEATH 146X
XXXXXXXXXXXXXXXX CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 August 2, 1957, to August 28, 1957 and XXXXXXXXXXXX him
Death occurred at 3:45 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) A. J. WILLIAMS, M.D. A. J. Williams
22b. ADDRESS VA Hospital, Kansas City, Mo.
22c. DATE SIGNED 8-28-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal Burial
23b. DATE 8-29-57
23c. NAME OF CEMETERY OR CREMATORY Memorial Park
23d. LOCATION (City, town, or county) (State) Kans City, Kans

24. FUNERAL DIRECTOR ADDRESS DW Newcomer Sons K.C. Ks.
25. DATE RECD. BY LOCAL REG. 8-29-57
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... Signed Robert E. Herron

Signature of Student Embalmer

Licensed Embalmer No. 1848

P. O. Address K.C. 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.