

Health,
& Welfare
Public
Service

FILED NOV 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **40527**
3154

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

5. 300
4
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION K. C. Conv. Home		Length of stay in 1b 40 Yrs.	d. STREET ADDRESS (If outside, give location) 3413 Garfield Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle JANE Last ROBIG			4. DATE OF DEATH Month 11- Day 3 Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-1880
9. AGE (In years birthday) 77		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (City and state or country) Lexington, Missouri
12. CITIZEN OF WHAT COUNTRY? U. S. A		13a. FATHER'S NAME John Maynard	
13b. MOTHER'S MAIDEN NAME Virginia Abbott		14. NAME OF HUSBAND OR WIFE Louis Robic	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/> Yes, <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Unknown <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address Mrs. Violet Rhoades 2210 E. 42nd. K. C. Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ch. Myocarditis DUE TO (b) Generalized Arterio Sclerosis DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH ? ? 4221
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 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 COUNTY STATE	
21. I attended the deceased from 1946 to 11/3/57 and last saw her alive on 11/3/57 Death occurred at 11/3/57 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J. W. Young M.D.		22b. ADDRESS 1401 S. W. Blvd. K.C. Mo.	22c. DATE SIGNED 11/4/57
23a. BURIAL, CREMATION, (Specify) Burial		23b. DATE 11-5-1957	23c. NAME OF CEMETERY OR CREMATORY Floral Hills
23d. LOCATION (City, town, or county) (State) Kansas City Missouri		24. FUNERAL DIRECTOR ADDRESS FLORAL HILLS MEMORIAL CHAPELS, INC. K.C. MO	
25. DATE RECD. BY LOCAL REG. 11-4-57		26. REGISTRAR'S SIGNATURE Neva Minshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
J. W. Young

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.

STATEMENT BY LICENSED EMBALMER

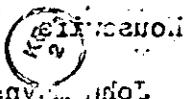
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student Signature of Student Embalmer

Signed *[Handwritten Signature]* Licensed Embalmer No. *3938* P. O. Address *[Handwritten Address]*

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.

File 510



John [unclear]