

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009631  
STATE FILE NUMBER 1344

FILED MAR 26 1959 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) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Lukes Hosp.</b>		Length of stay in lb <b>25 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>4275 Jefferson</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Nina</b> Middle <b>Robe</b> Last <b>Robe</b>			4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>1959</b>		
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5. SEX <b>Female</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>Feb. 21, 1896</b>	9. AGE (In years last birthday) <b>63</b> IF UNDER 1 YEAR Months Days Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>at home</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Lebanon, Texas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>John W. Orendoff</b>	13b. MOTHER'S MAIDEN NAME <b>Janie Work</b>	14. NAME OF HUSBAND OR WIFE <b>Leroy Robe</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT Address <b>Allen Robe, 237 Sunset Ave. Heights Town, W. I.</b>
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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>malignant Effusion o Vascular Collapse</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Metastatic Carcinoma Stomache</b>	<b>1 year</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>massive ascites</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)	
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20c. TIME OF INJURY Hour _____ 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
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21. I attended the deceased from <b>1-13-58</b> to <b>3/11/59</b> and last saw her alive on <b>3/11/59</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Morgan U. Stockwell M.D.</b>	22b. ADDRESS <b>2500 Johnson Dr. S.C. 3, Ks.</b>	22c. DATE SIGNED <b>3/13/59</b>
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23a. BURIAL CREMATION REMOVAL <b>Removal</b>	23b. DATE <b>Mar 15, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>—</b>	23d. LOCATION (City, town, or county) (State) <b>Henrietta, Oklahoma</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Stine &amp; McClure K.C.Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-13-59</b>	26. REGISTRAR'S SIGNATURE <b>Irene Marshall</b>
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All diseases in Part I must be causally related. Morgan U. Stockwell, M.D. MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

25200 J. L. ... - 112M

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 Eugene L. ...

Licensed Embalmer No. 4633 P. O. Address R E M O

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.